K.A.R.A.T.

Kingston Area Riding Assisted Therapy

Physician's Referral Form:

Name of Client: ____ Date of Birth:
Address:____

Phone (home):_______________________(work):______________________________(cell):___________

Next of kin/Guardian:____

Living at home?:________________________________Other:_____________________________________

Medical:

Primary Diagnosis:____

Secondary Diagnosis:____

Height:_____________Weight:_______________Gender:_____________________________

Diabetic?:_________Insulin?:_______________

Epileptic?:____________ Frequency of Seizures?:_____________Date of last seizure?:______________

Medications:____

Reason for medication:____

Communicable disease: Yes_______No______

If yes, explain:____

Surgery:_________________________attach a sheet if more space needed _____Date:_______________

Ambulatory: Yes_________No_________ If yes, explain:____

Muscle Tone (spasticity, flaccidity, etc.):

Upper extremities:____

Lower extremities:____

Tone in trunk:____

Balance sitting:____________________Standing:__________________Walking:______________________

Language (check): English:________French:_______Sign Language:______Other:___________________

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Speech (check): Good: __________Fair: ___________Poor: _________

Ability to understand (check): Good: _____________Fair: __________Poor: _________

Sensory Function(Good, Fair, Poor): Sight:______________ Hearing:____________Tactile:__________
Continence:______________

Allergies:____

Physician's signature:____Date:______________________

Physician's name (please print):____

*details ie. height, weight, etc. will be used by program to best match rider with mount as well as to determine the proper amount of volunteers needed to best assist the rider