Email: director@soleanastables.org • 713-436-6625
www.soleanastables.org
Physical Address: Big Wish Farm 19200 McKay Rd., Alvin, Texas 77511
Mailing Address: P.O. Box 84955, Pearland, Texas 77584

Letter to Physician

Dear Physician:

One of your patients is interested in participating in supervised equestrian activities.

In order to safely provide this service, we request that you complete the attached Physician Assessment and Physician Release forms. Please note that the following conditions may present precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic:

- Atlantoaxial Instability-include neurologic symptoms
- Contractures
- Coxa Arthrosis
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Instability/Abnormalities
- Spinal Fusion/Fixation
- Scoliosis 30 degrees or greater

Neurologic:

- Hydrocephalus/Shunt
- Neuromuscular Disorders (if pain or fatigue increases with the activity)
- Uncontrolled Seizures
- Tethered Cord Symptoms Chiari II Malformations, Hydromyelia Symptoms (all are associated with Spina Bifida)
- Spinal Cord Injury (contraindication if injury is above T-6)

Medical/ Psychological:

- Allergies
- Animal Abuse
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions
- Hemophilia
- Medical instability
- PVD
- Respiratory Compromise

Other:

- Age: under 4 years
- Indwelling Catheters
- Medications – i.e., photosensitivity
- Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic riding activities, please feel free to contact me by phone at 713-436-6625 or by email at director@soleanastables.org.

Warm regards,
Sasha L. Camacho
Executive Director of SoléAna Stables

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Physician Assessment

(This Form Must Be Completed in Full and Signed by Participant's Physician)

Patient's Name: _____ Parents/Caregiver: _____
Address: _____
Date of Birth: _____ Height: _____ Weight: _____
Diagnosis: _____
Hospitalization/Surgery (Date & Reason): _____
Medications: _____
Shunts/Implants/Appliances: _____ Date of last revision: _____
Allergies: _____
Is a Seizure Disorder present? _____ Controlled? _____ Date of last Seizure: _____
Seizure Type: _____
Mobility (Independent/Assisted/Wheelchair): _____
Special Precautions/Needs: _____

Please Indicate Current or Past Special Needs in the Following Areas:

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Tactile Senstaion			
Cardiac			
Skin/Circulatory			
Pulmonary			
Neurological/Sensation			
Muscular			
Orthopedic			
Bowel/Bladder			
Allergies			
Immunity			
Cognition			
Psychological/Emotional			
Amputations			
Balance/Coordination			
Pain			
Other			

Date: _____ Participant or Parent/Caregiver Signature: _____
Date: _____ Physicians Signature: _____

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Physician Release

To my knowledge there is no reason why _____
(*Patient's Name*)
cannot participate in supervised equestrian activities. However, I understand that SoléAna Stables will weigh the medical information contained in the physician release form against existing precautions and contraindications. Therefore, I refer this person to SoléAna Stables for ongoing evaluation to determine eligibility for participation.

Physician's Signature: _____ Date: _____

Participants with Down syndrome

PATH International standards require that all participants with Down syndrome provide annual proof of a complete neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI). AAI is an instability or dislocation of the joints between the first and second cervical vertebrae that could result in serious injury or paralysis. **A Cervical X-Ray is no longer required, however, if the participant has had one done previously for Atlantoaxial Instability please indicate results below.**

Cervical X-Ray for Atlantoaxial Instability: Positive: _____ Negative: _____ X-Ray Date: _____

Please provide the following:
Date of last neurologic exam _____
Symptoms of atlantoaxial instability (AAI) present? Yes_____ No _____

Additional Comments: _____

_____

_____

Physician's Signature: _____ Date: _____

Physician's name, address & telephone number (please print, type or stamp):

_____

_____

_____