# Physician's Release

*To be completed by participant's physician.*

*This form must be updated annually and submitted with required signatures.*

**Physician, please note** - the conditions noted on the accompanying medical history, if present, may represent precautions or contraindications to equine assisted activities. Therefore, when reviewing the medical history, please note whether these conditions are present and to what degree. Please be as specific as possible so that we may best serve the client's needs.

**Rhythms of Grace will make the final determination about an individual's ability to participate in the program.**

Patient Name: _____ Date of Birth: _____

Patient Primary Diagnosis: _____ ICD 10 Code: _____

Secondary Diagnosis: _____ Other: _____

Height: _____ Weight: _____

Specific limitations not noted on the medical history: _____

**ALL Participants with Down Syndrome - PLEASE NOTE:**

Due to the nature of Equine Assisted Activities and Therapies, we require that ALL individuals diagnosed with Down Syndrome must have an ANNUAL certification from their physician that a neurological and/or physical examination reveals no sign of AAI or decrease in neurological function:

A) **Annual** neurological/physical exam for AAI/decreased neurological function: ☐ Positive ☐ Negative Exam Date: _____

B) Most recent cervical x-ray for AAI: ☐ Positive ☐ Negative X-Ray Date: _____

I have reviewed the attached medical history and release my patient to participate in appropriate programming at Rhythms of Grace. I am aware and permit my patient to actively participate in the following areas (*check all that apply*):

Sitting astride a horse: ☐ Yes ☐ No Other equine related ground activities: ☐ Yes ☐ No

Grooming horses: ☐ Yes ☐ No

Given the above diagnosis and medical information, I affirm that this person is not medically precluded from participating in supervised equine-assisted activities. I understand that Rhythms of Grace instructors and therapists will weigh all medical information against any precautions and contraindications. Therefore, I refer this person to Rhythms of Grace for ongoing evaluation to determine further eligibility for participating in supervised equine-assisted activities.

Physician Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other: _____

License/UPIN #: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Physician's Signature: _____ Date: _____

**When completed with ALL SIGNATURES please return this form to:**

**Rhythms of Grace**
**23625 River Heights Dr., Dallas Center, IA 50063**
**Phone: (515)305-7361 | Email: Info@RhythmsOfGraceEquine.org**

# Physician's Prescription Form

***To be completed by participant's physician for PT Only.***
***Please provide BOTH Diagnosis and ICD 10 Code -***
***incomplete forms will be returned.***

Client Name: _____ Date of Birth: _____

Primary Dx: _____ ICD 10 Code: _____

Secondary Dx: _____ ICD 10 Code: _____

**Clinical Comments:**

Evaluate and treat, to include ☐ Physical Therapy as a treatment tool.
Frequency: Treatment as needed based on Therapist evaluation.

This prescription will be current for one year (12 months) from date of Physician's Signature.

Physician Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other: _____

License/UPIN #: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Physician's Signature: _____ Date: _____

**When completed with <u>ALL SIGNATURES</u> please return this form to:**

**Rhythms of Grace**
**23625 River Heights Dr., Dallas Center, IA 50063**
**Phone: (515) 305-7361 | Email: Info@RhythmsOfGraceEquine.org**