RISE Therapeutic Equestrian Center ~ Home of RISE Rehab

Physician's Prescription for Physical, Occupational or Speech Therapy

Client's Name: _____ Phone: _____

This is a prescription for the evaluation and treatment by a Physical Therapist, Occupational Therapist or Speech Therapist.

Recommended Frequency: 1 X per week OR as noted by physician here:

_____

Physician's Signature: _____ ***Date:*** _____

Please print, type or stamp

Physician's Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

The following conditions may suggest precautions and/or contraindications to specific treatment strategies. Please indicate if these conditions are present and if so, to what degree.

Orthopedic:

- ☐ Spinal Fusion
- ☐ Spinal Instability
- ☐ Atlantoaxial Instabilities
- ☐ Coxa Arthrosis
- ☐ Cranial Deficits
- ☐ Heterotopic Ossificans/Myositis Ossificans
- ☐ Joint subluxation/dislocation
- ☐ Osteoporosis
- ☐ Osteogenesis Imperfecta
- ☐ Spinal/Internal Orthoses
- ☐ Scoliosis
- ☐ Pathological fractures

Neurological:

- ☐ Paralysis due to Spinal Cord Injury
- ☐ Hydrocephalus/Shunt
- ☐ Seizure
- ☐ Spina Bifida
- ☐ Chiari II Malformation
- ☐ Tethered Cord
- ☐ Hydromyelia

Medical/Surgical

- ☐ Cancer
- ☐ Recent surgery
- ☐ Animal Abuse
- ☐ Physical/Sexual/Emotional Abuse
- ☐ Dangerous to self or others
- ☐ Medications/allergies
- ☐ Heart condition
- ☐ Hemophilia
- ☐ PVD
- ☐ HTN
- ☐ Recent surgeries
- ☐ Substance abuse
- ☐ Indwelling Catheter
- ☐ poor endurance
- ☐ Skin breakdown
- ☐ Poor Endurance
- ☐ Diabetes
- ☐ Acute exacerbation of disorder
- ☐ Varicose Veins

please use next page to elaborate on any conditions checked

Comments:_____