811 N. 500 Rd., Baldwin City, KS 66006 ~ Phone/Fax: 785.594.3827 ~ Email: Pathwaysaat@yahoo.com ~ www.pathwaysaat.com

PHYSICIAN'S PERMISSION

Physician's permission required only for riders with physical or cognitive disabilities.

Client's Name: ____ Phone: ____________________________

Permission for Therapeutic Horseback Riding
In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Diagnostic Code:____

Recommended Frequency: ____

Precautions:____

____

____

Physician's Signature:____ Date:__________________

Please print, type or stamp.
Physician's Name: ____

Doctor's UPIN # / Provider #: ____

Address: ____

City:____ State: ________ Zip:_______________

Phone: ____ Fax: __________________________________