Therapeutic Riding Registration

TODAY'S DATE _____

CLIENT NAME: _____ DOB: _____

REFERRING ORGANIZATION

ORGANIZATION: _____ CONTACT PERSON: _____

PHONE: _____ EMAIL: _____

HOW WILL THESE SERVICES BE PAID FOR? (CHECK ONE)

❑ WPS ❑ CCS ❑ County ❑ LSS ❑ Other_____

If the assessment/services are funded through the Children's Waiver (WPS), we need the Authorizations on or before the day of assessment and before services are rendered.

Assessment Authorization must be for the date of the assessment appointment only and in the amount of $150.
Ongoing Services Authorization must have all pertinent information, including the start/end date of authorization, the appropriate service codes, definition of unit, unit rates and number of approved units.

BILLING AGENCY'S INFORMATION:

NAME OF AGENCY: _____

ADDRESS: _____

CONTACT PERSON: _____

BASIC FAMILY DEMOGRAPHICS

LEGAL GUARDIAN: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

MOTHER'S ADDRESS: _____ FATHER'S ADDRESS: _____

_____ _____

MOTHER'S PHONE: _____ FATHER'S PHONE: _____

SIBLINGS (NAMES, AGES, NOTE IF IN SAME HOUSEHOLD): _____

_____

SIGNIFICANT FAMILY INFORMATION:

CLIENT'S STRENGTHS & POSITIVE CHARACTERISTICS

PRESENTING ISSUES (CHECK ALL THAT APPLY)

❑ AODA	❑ Suicide Tendencies	❑ Property Destruction	❑ Enuresis/ Encopresis	❑ Sexually Active
❑ Delinquency	❑ Sexually Abused	❑ Gang Affiliation	❑ Sexually Inappropriate	❑ Medical Concerns
❑ Depression	❑ Physically Abused	❑ Attachment Issues	❑ Animal Cruelty/ Fear	❑ Eating Disorder
❑ Smoking	❑ Physically Aggressive	❑ Emotionally Abused	❑ Cognitively Delayed	❑ Elopement
❑ Fire Setting	❑ Verbally Aggressive	❑ Other:		

EXPLAIN PRESENTING ISSUES

Client History

PRIOR PLACEMENTS

❑ AWOL	❑ Foster Home	❑ Hospital	❑ Corrections	❑ JCI
❑ Group Home	❑ Detention	❑ Shelter	❑ Respite	❑ Home
❑ Relative's Home	❑ Adoptive Home	❑ Home	❑ Unknown	❑ Other

NAME OF PLACEMENT:	DATES	STATUS (Progress/Reason for Leaving)

THE CHILD IS BEING REFERRED FOR ASSISTANCE IN THE FOLLOWING AREAS (CHECK ALL THAT APPLY):

- ❑ Academic Issues
- ❑ Behavioral Issues
- ❑ Delinquency
- ❑ Vocational Training
- ❑ Self-Esteem
- ❑ Study Habits
- ❑ Social Skills
- ❑ Peer Relationships
- ❑ Family Issues
- ❑ Special Needs
- ❑ Attitude
- ❑ Other, specify:

ON A SCALE OF 1-10 (10 BEING HIGHEST) RATE THE STUDENTS' LEVEL OF:

_____ Academic performance
_____ Social skills
_____ Self-esteem
_____ Family support
____Communication skills
____Attitude about school/education
____Peer relations

MEDICAL/PSYCHIATRIC HISTORY

MENTAL HEALTH DIAGNOSIS:

PSYCHIATRIST, PSYCHOLOGIST, THERAPIST / CLINIC (INCLUDE HOW OFTEN SEEN AND LAST APPT.):

HISTORY OF EXPLOSIVE BEHAVIOR? YES ◯ NO ◯ TRIGGERS?_____

DE-ESCALATING METHODS: _____

PHYSICAL ISSUES / ALLERGIES: _____

PRIMARY CARE PHYSICIAN: _____ WHERE:_____

MEDICATIONS/ REASONS/ DOSAGES/ SIDE EFFECTS:

RISK ASSESSMENT

HISTORY OF SUICIDE/ SELF HARM/ HOMICIDAL IDEATION:

PSYCHIATRIST, PSYCHOLOGIST, THERAPIST / CLINIC (INCLUDE HOW OFTEN SEEN AND LAST APPT.):

CURRENT POTENTIAL DANDER TO SELF: ❑ Yes ❑ No

SELF HARM / MUTILATION: ❑ Yes ❑ No

SUICIDAL IDEATION: ❑ Yes ❑ No

DANGER TO ANIMALS: ❑ Yes ❑ No

DESCRIBE SAFETY PLAN:

DESCRIBE RELATED SAFETY PLAN:

GENERAL SAFETY PLAN

Describe steps to take in case of behavioral or mental health crisis while at Trinity Equestrian Center. Include names and phone numbers of support people along with any other relevant information.

COURT DISPOSITION

❑ CHIPS ❑ JIPS ❑ Delinquent ❑ CH. 51 ❑ Voluntary ❑ TPR

COURT REPORTS: Date Requested:_____ Date Received: _____

PSYCH EVALS: Date Requested: _____ Date Received: _____

PREVIOUS TX: Date Requested:_____ Date Received: _____

SCHOOL RECORDS: Date Requested: _____ Date Received: _____

SCHOOL

❑ Regular ED ❑ Special ED ❑ LD ❑ CD

❑ Mainstream ❑ Partial Mainstream ❑ Self-Contained Classroom

SCHOOL ATTENDING:_____ GRADE LEVEL: _____

CLASSROOM TYPE: ❑ Self Contained ❑ Partial Mainstream ❑ Total Mainstream

HISTORY OF: ❑ Truancy ❑ Suspension ❑ Expulsion

CONTACT PERSON: _____PHONE: _____

OTHER SIGNIFICANT SCHOOL INFORMATION:

DISPOSITION

APPROPRIATE FOR ENROLLMENT IN HEALING WITH HORSES? ❑ Yes ❑ No

IF YES, WHAT PROGRAM? ❑ EAP ❑ Therapeutic Riding ❑ Youth Groups ❑ Mentoring

IF NO, PLEASE EXPLAIN:

OTHER SERVICES RECOMMENDED:

NOTES

MENTAL HEALTH PROFESSIONAL SIGNATURE: _____DATE: _____

Trinity Equestrian Center - Physician Release

PATIENT NAME: _____ DATE: _____

CONTRAINDICATION

The presence of a contraindication makes this activity inappropriate. Few contraindications are clear-cut. A contraindication may be permanent. For instance, some activities may never be appropriate for certain participants due to safety or health concerns. A contraindication may be temporary. Activities may only be contraindicated until appropriate conditions exist at a center or until a participant's health condition improves enough to make participation safe. If a particular activity is contraindicated, alternative equine activities may be explored. For example, if riding is contraindicated, driving or unmounted sessions may be appropriate and beneficial.

Contraindication:

- Children under the age of three
- Neurologic symptoms of atlantoaxial instability
- Significant AAI measurement as determined by the physician
- Excessive head/neck instability with or without a helmet
- Complete spinal cord injury above T-6
- Inability to position participant in midline
- uncontrolled asthma, seizures

DIAGNOSIS

PRIMARY DIAGNOSIS: _____ DATE OF ONSET: _____

SECONDARY DIAGNOSIS: _____ DATE OF ONSET: _____

PAST/PROSPECTIVE SURGERIES: _____

SHUNT PRESENT: ❑ Yes ❑ No IF YES, DATE OF LAST REVISION: _____

SEZURES: ❑ Yes ❑ No CONTROLLED: ❑ Yes ❑ No DATE OF LAST SEIZURE: _____

MEDICATIONS AND WHAT ARE THEY FOR:

AMBULATION: ❑ Independant ❑ Assisted ❑ Wheelchair

INCONTINENCE: ❑ Yes ❑ No TETANUS SHOT: ❑ Yes ❑ No DATE: _____

SPECIAL PRECAUTIONS:

CHALLENGES

AUDITORY: ❑ Yes ❑ No COMMENT: _____

VISUAL: ❑ Yes ❑ No COMMENT: _____

SPEECH: ❑ Yes ❑ No COMMENT: _____

CARDIAC: ❑ Yes ❑ No COMMENT: _____

CIRCULATORY: ❑ Yes ❑ No COMMENT: _____

PLUMONARY: ❑ Yes ❑ No COMMENT: _____

NEUROLOGICAL: ❑ Yes ❑ No COMMENT: _____

MUSCULAR: ❑ Yes ❑ No COMMENT: _____

ORTHOPEDIC: ❑ Yes ❑ No COMMENT: _____

LEARNING DISABILITY OR EMOTIONAL/BEHAVIORAL DISORDER:

❑ Yes, in my opinion this patient can participate in the Trinity Equestrian Center Therapeutic Riding Program, under appropriate supervision

❑ No, in my opinion this patient should not participate in the Trinity Equestrian Center Therapeutic Riding Program.

GENERAL COMMENTS:

AUTHORIZATION

PATIENT NAME (Please print): _____

ADDRESS: _____

PHONE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

PLEASE NOTE: FOR INDIVIDUALS WITH DOWN SYNDROME ONLY

Because of the nature of the horseback riding activity, no individual diagnosed with Down Syndrome can be accepted for riding instruction without the proof of a negative diagnostic X-ray for Atlantoaxial Dislocation Condition.

Physician's Acknowledgement:
I have X-rayed this patient for Atlantoxial Dislocation Condition and the results are negative. In addition, this patient does not display signs or symptoms of ADC and may participate in the Trinity Equestrian Center Therapeutic Riding Program.

DATE OF LAST X-RAY: _____

PATIENT SIGNATURE: _____ DATE: _____

Trinity Equestrian Center - Program Goals

CLIENT NAME: _____DATE: _____

PROGRAM GOALS

1.

2.

3.

CLIENT SIGNATURE (if over 14 years old): _____DATE: _____

PARENT/GUARDIAN SIGNATURE:_____DATE: _____

TRINITY REPRESENTATIVE: _____DATE: _____