Rainbow Riders
Therapeutic Riding Centre

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Dear Primary Care Provider,

One of your patients has contacted our organization expressing an interest in joining our Therapeutic Riding Program. Enclosed is a Primary Care Provider Referral Form and a list of both **absolute** and **relative contraindications** for Therapeutic Riding.

Please review the list of contraindications and consider any that may be applicable for your patient. As well, please review the list of conditions that require cervical spine and/or flexion-extension x-rays. If an x-ray is indicated, please attach to this referral a copy of the x-ray report confirming the patient's ability to participate in athletic activities—specifically, horseback riding. Where applicable in this referral, please be specific with your comments. Your expertise will assist our instructors in deciding this patient's suitability for riding, and help us to provide the most beneficial individualized program.

Horseback riding is considered a risk sport; therefore the highest standards of safety and therapeutic riding instruction, as per the Canadian Therapeutic Riding Association (CanTRA), are maintained. Please feel free to contact us with any questions. Thank you for your cooperation!

Sincerely,

KSandoval

Kelly Sandoval
Executive Director
(709)738-1055
ksrainbowridersnl@gmail.com

Guidelines for Primary Care Providers / Therapists
CONTRAINDICATIONS AND PRECAUTIONS FOR THERAPEUTIC RIDING

The following conditions may represent precautions or contraindications to therapeutic horseback riding if present in potential participants. Therefore, when completing the primary care provider's referral, please note whether these conditions are present and to what degree.

ABSOLUTE CONTRAINDICATIONS

ORTHOPAEDIC
- Acute arthritis
- Acute herniated disc or prolapsed disc
- Atlanto-axial instabilities
- Coax arthrosis (degeneration of hip joint)
- Structural cranial deficits
- Osteogenesis imperfecta
- Pathological fractures
- Spondylolisthesis
- Structural scoliosis >30 degrees, excessive kyphosis or lordosis or hemivertebra
- Spinal stenosis
- Hip subluxation, dislocation or dysplasia (one hip)

NEUROLOGICAL
- CVA secondary to unclipped aneurysm or angioma
- Paralysis due to spinal cord injury above T6 (adult)
- Spina bifida associations – Chiari II malformations, hydromyelia, tethered cord
- Uncontrolled seizures within the last 6 months

MEDICAL
- Obesity or >170 lbs

RELATIVE CONTRAINDICATIONS AND PRECAUTIONS

OTHER
- Age under 2 years old
- Any condition that the instructor, therapist, physician or program does not feel comfortable accepting into the program

ORTHOPAEDIC
- Arthrogryposis
- Heterotopic ossification
- Hip subluxation, dislocation or dysplasia
- Osteoporosis
- Spinal fusion/fixation, Harrington Rod (within 2 years of surgery)

• Spinal instabilities/abnormalities
• Spinal orthoses

NEUROLOGICAL
• Amyotrophic Lateral Sclerosis
• Fibromyalgia
• Gullian Barre Syndrome
• Exacerbation of Multiple Sclerosis
• Post Polio Syndrome
• Hydrocephalic shunt

MEDICAL / PSYCHOSOCIAL
• Abusive or disruptive behaviour
• Cancer
• Hemophilia
• History of skin breakdown or skin grafts
• Abnormal fatigue
• Incontinence (must wear protection)
• Peripheral vascular disease
• Sensory deficits
• Serious heart condition or hypertension
• Significant allergies
• Surgery within the last three months
• Uncontrolled diabetes
• Indwelling catheter •
Substance abuse
• Anticoagulants (bleeding risk)

FLEXION/EXTENSION X-RAY REQUIRED FOR ATRAUMATIC FACTORS THAT MAY BE ASSOCIATED WITH AN UNSTABLE UPPER CERVICAL SPINE
• Down syndrome
• Os odontoideum
• Athetoid cerebral palsy
• Rheumatoid arthritis of cervical vertebrae
• Congenital torticollis
• Sprengel's deformity
• Ankylosing spondylitis
• Congenital atlanto-occipital instability
• Klippel-Feil syndrome
• Chiari malformation with condylar hyperplasia
• Fusion of C2-C3
• Lateral mass degeneration change at C1-C2
• Systemic lupus
• Morquio disease
• Non-rheumatoid cranial settling
• Subluxation of upper cervical vertebrae due to tumours or infection
• Idiopathic laxity of the ligaments
• Grisel’s syndrome
• Lesch-Nyhan syndrome
• Marshall-Smith syndrome
• Diffuse idiopathic hyperostosis
• Congenital chondrodysplasia

Rainbow Riders Therapeutic Riding Newfoundland and Labrador Inc.
103 Mount Scio Road
P.O. Box 23199
St. John's, NL A1B 4J9

PRIMARY CARE PROVIDER REFERRAL FORM

ATTENTION: Please ensure all fields are complete (e.g. height, weight etc.) in order for the instructor and/or physiotherapist to match the rider with an appropriate horse.

PATIENT'S FULL NAME	
HEIGHT	WEIGHT
Date of Birth	Contact Phone Number
Contact Email	Home Address

PRIMARY DIAGNOSIS		DATE ON ONSET
SECONDARY DIAGNOSES		DATE OF ONSET
PLEASE BE SPECIFIC WHEN COMMENTING ON IMPAIRMENTS		If atypical, comments…
AUDITORY IMPAIRMENTS	YES NO	
VISUAL IMPAIRMENTS	YES NO	
SPEECH IMPAIRMENTS	YES NO	
BEHAVIOURAL OR PSYCHOLOGICAL CONCERNS	YES NO	
CIRCULATORY IMPAIRMENTS	YES NO	

NORMAL SENSATION	YES NO			
INCONTINENCE	YES NO			
SEIZURE DISORDER*	Type: DATE OF LAST SEIZURE:		Meds:	
DIABETIC	TYPE I		TYPE II	
HIP SUBLUXATION OR DISLOCATION*	LEFT	RIGHT	BOTH	
***Please refer to Contraindications and Precautions**				
SPINAL OR JOINT ABNORMALITIES	YES	NO	If yes, explain…	
GROSS MOTOR SKILLS	GOOD	FAIR	POOR	COMMENTS
FINE MOTOR SKILLS	GOOD	FAIR	POOR	COMMENTS
BALANCE (SITTING)	GOOD	FAIR	POOR	COMMENTS
BALANCE (STANDING)	GOOD	FAIR	POOR	COMMENTS
MUSCLE TONE	NORMAL	HIGH	LOW	COMMENTS

MEDICATIONS (Please specify) Attach separate sheet as necessary or preferred	
RELEVANT MEDICATION SIDE EFFECTS: (eg: aggression, lethargy, dizziness, bleeding risk, etc)	
RELEVANT SURGERIES AND DATES (eg: spinal rods/fusion)	
ASSISTIVE DEVICES, BRACE, BOTOX DATES (Please specify)	
SHUNTS	
COMMUNICABLE DISEASES	

ALLERGIES (Please specify)	Epinephrine autoinjector: YES NO
IMMUNIZATIONS UP TO DATE (including COVID-19 for ages 5+)	
DOWN SYNDROME & RHEUMATOID ARTHRITIS X-RAYS (see contraindications) **Must have been within 5 previous years, and redone every 5 years until adulthood.**	YEAR AND DETAILS (attach report)

COMMENTS:

Please ensure you have consulted our CONTRAINDICATIONS on pages 2-3 of this document.

Does this patient have any ABSOLUTE contraindications? YES NO

Does this patient have any RELATIVE contraindications? YES NO

Having reviewed the absolute contraindications and relative contraindications to therapeutic riding, my patient's medical history and all indicated X-rays, I certify that there is no medical reason prohibiting this individual from engaging in therapeutic horseback riding.

Signature: _____ Date: _____

This clearance is good for… (Please circle one)	ONE year	TWO years	FIVE years

PRIMARY CARE PROVIDER'S NAME	MEDICAL DESIGNATION
ADDRESS	CITY/POSTAL CODE