IRONSTONE THERAPY, INC.

PHYSICIAN'S REFERRAL

Client Name: ____ DOB: ______________

____ Physical Therapy ____Occupational Therapy ____ Speech Therapy

Primary Diagnosis:
(with ICD 10 codes)

Secondary Diagnosis:
(with ICD 10 codes)

Special Precautions/Needs (See list on back page):
____
____
____

For Clients with Down Syndrome:
AtlantoAxial X-Ray, date:_______ Result for subluxation: Positive negative
Neurological Symptoms of AtlantoAxial Instability: ___________________________________
____

To my knowledge there is no reason why this person cannot participate in equine assisted therapies.

Date: ______________________

____ **Telephone:** __________________
Signature of Referring Physician

____ ______________________________
Printed Name of Physician **NPI #**

____
Printed Address of Physician

Information for Physicians

The following conditions, if present may represent precautions or contraindications to equine assisted activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.
If you have any questions or concerns, please feel free to contact us at 978.475.4056.

Contraindications:
Indwelling Catheter

Orthopedic:
Spinal Joint Fusion/Fixation
Spinal Joint Instabilities/Abnormalities
Atlantoaxial Instabilities (incl. Neurological symptoms)
Joint Subluxation/Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification/Myositis Ossification
Osteogenesis Imperfecta
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurological:
Hydrocephalus/Shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Seizure Disorders
Multiple Sclerosis

Medical /Psychological:
Allergies
Hemophelia
Cardiac Condition