

## Application for Therapy Services

Patient Name \_\_\_\_\_

Parent/Guardian Names \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address : \_\_\_\_\_

Please circle preferred method of contact:    home        cell        e-mail  
 Most convenient time of day for phone call is: \_\_\_\_\_

Patient date of birth \_\_\_\_\_

Diagnosis \_\_\_\_\_ Date of Onset \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Father's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Code \_\_\_\_\_

No patient will be accepted for therapy until the Parent/Guardian has completed this form. If the patient is of legal age and mentally competent, s/he may complete the form without parental/guardian supervision. Every effort will be made to avoid any accident; however, **NO LIABILITY** can be accepted by any of the organization's trustees, agents, employees, each and every one of its members and associates, the property owners upon whose land the therapy is conducted.

I would like \_\_\_\_\_ to participate in TROT Therapy Services which may include the use of hippotherapy. I have discussed this with the child's (my) doctor. Furthermore, I grant permission for a TROT therapist to contact my doctor or therapist for further clarification of medical information if needed (this information will be treated confidentially). I also grant permission for my TROT therapist to discuss with my treatment team any medical information that is necessary for a safe and effective treatment. I understand that **NO LIABILITY** can be accepted by any of the organizations concerned with this therapy, including Therapeutic Riding of Tucson (TROT), INC. and TROT Therapy Services. I understand that the final decision regarding acceptance, selected therapeutic activities, and continued services rests upon TROT therapists, upon due consideration for the individual's special needs and the safety of the participant, staff, volunteers, and horses.

**SIGNATURE OF PARENT/GUARDIAN/ PATIENT OF LEGAL AGE:**

\_\_\_\_\_ **DATE** \_\_\_\_\_

## Intake Questionnaire

Child's Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Hgt:\_\_\_\_ Wgt:\_\_\_\_

Primary language spoken at home \_\_\_\_\_

Why are you bringing this child in for an evaluation? \_\_\_\_\_

### **PREGANCY - did the child's mother..**

- |                                  |     |    |
|----------------------------------|-----|----|
| 1. Smoke, take drugs, or alcohol | YES | NO |
| 2. Experience complications      | YES | NO |

**Please explain YES answers** \_\_\_\_\_

### **BIRTH HISTORY**

- |                    |     |    |                       |       |    |
|--------------------|-----|----|-----------------------|-------|----|
| 1. Premature       | YES | NO | 5. Cord around neck   | YES   | NO |
| 2. Birth Injuries  | YES | NO | 6. Incubation         | YES   | NO |
| 3. Oxygen required | YES | NO | 7. Time spent in NICU | _____ |    |
| 4. Birth defects   | YES | NO | 8. Birth Weight       | _____ |    |

**Please explain YES answers** \_\_\_\_\_

### **NEONATAL HISTORY**

- |                              |     |    |             |     |    |
|------------------------------|-----|----|-------------|-----|----|
| 1. Difficulty sucking/eating | YES | NO | 4. Jaundice | YES | NO |
| 2. Fussy, excessive crying   | YES | NO | 5. Colic    | YES | NO |
| 3. Difficulty gaining weight | YES | NO | 6. Reflux   | YES | NO |

**Please explain YES answers** \_\_\_\_\_

### **HEALTH HISTORY**

- |                            |     |    |                          |     |    |
|----------------------------|-----|----|--------------------------|-----|----|
| 1. Frequent ear infections | YES | NO | 5. Meningitis            | YES | NO |
| 2. Frequent high fevers    | YES | NO | 6. Serious accident      | YES | NO |
| 3. Multiple falls          | YES | NO | 7. Loss of consciousness | YES | NO |
| 4. Severe allergies:       | YES | NO |                          |     |    |

**Please explain YES answers** \_\_\_\_\_

8. List recent medical procedures/surgeries \_\_\_\_\_

8. Medical specialists seen and why \_\_\_\_\_

9. Year and results of: a. Hearing test \_\_\_\_\_

b. Vision test \_\_\_\_\_

10. Current Medications: \_\_\_\_\_

11. Mobility

Preferred Method: (scooting? crawling? walking, etc) \_\_\_\_\_

Assistive devices: (wheelchair, walker, crutches, etc) \_\_\_\_\_

12. Orthotics (type and how often worn) \_\_\_\_\_

13. Seizures: YES NO (if yes, please describe type and frequency and cause if known) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Developmental Milestones**

	Years	Months		Years	Months
Rolled			Began Babbling		
Sat when placed			Spoke first words		
Sat without arm support			Followed simple directions		
Held toy with 2 hands			Spoke simple sentences		
Crawled			Ate pureed foods		
Pulled to stand			Ate table foods		
Walked alone			Fed Self		

**Activities of Daily Living**

<b>Dressing</b>	shoes	socks	shirt	pants
✓ if help needed:				
<b>Grooming</b>	brushing teeth	hair	shower/bathing	toileting
✓ if help needed:				

Space is provided if you need to share any additional information about activities of daily living \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SENSORY/BEHAVIORAL QUESTIONS:**

1. Does your child eat a variety of foods YES NO
2. Is your child able to transition from one activity to another easily YES NO
3. Is your child able to transition from one place to another easily YES NO
4. Does your child demonstrate appropriate play skills with peers YES NO
5. Does your child play with toys appropriately YES NO
6. Does your child demonstrate age appropriate attention YES NO
7. Does your child sleep well YES NO

Please explain any "NO" answers \_\_\_\_\_

\_\_\_\_\_

8. What are your child's favorite things? \_\_\_\_\_
9. What are your child's least favorite things? \_\_\_\_\_

**SOCIAL HISTORY**

1. Does your child have siblings? \_\_\_\_\_
2. Does your child reside with both natural parents \_\_\_\_\_
3. Where is the child during the day \_\_\_\_\_
4. Is your child able to comprehend verbal instruction YES NO \_\_\_\_\_
5. Is your child able to make wants & needs known YES NO \_\_\_\_\_

**CURRENT THERAPY (if applicable)**

Name and phone number of present therapist(s)

OT \_\_\_\_\_ Phone: \_\_\_\_\_

PT \_\_\_\_\_ Phone: \_\_\_\_\_

ST \_\_\_\_\_ Phone: \_\_\_\_\_

**PHYSICAL, OCCUPATIONAL, or SPEECH/LANGUAGE THERAPY INFORMATION**

To be completed by child's primary therapist (PT, OT or ST). \*If child is not receiving PT/ OT/ or ST services at this time, please sign here to indicate that this form does not apply:

Signature \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Diagnosis \_\_\_\_\_

Address \_\_\_\_\_ City/ST \_\_\_\_\_ Zip \_\_\_\_\_

Therapist: \_\_\_\_\_ Phone \_\_\_\_\_

Muscle tone \_\_\_\_\_

ROM / JT. Deformities \_\_\_\_\_

Balance / coordination \_\_\_\_\_

Self-help skills \_\_\_\_\_

Mobility \_\_\_\_\_

Assistive devices \_\_\_\_\_

Posture / scoliosis \_\_\_\_\_

Associated reactions / abnormal reactions \_\_\_\_\_

Comprehension of verbal instructions \_\_\_\_\_

Speech / language \_\_\_\_\_

Sensory Processing \_\_\_\_\_

Psychosocial / Behavioral \_\_\_\_\_

\_\_\_\_\_

Exercises or positions to avoid \_\_\_\_\_

Other special precautions \_\_\_\_\_

\_\_\_\_\_

Present goals of PT / OT / ST program: \_\_\_\_\_

\_\_\_\_\_

SIGNED \_\_\_\_\_

DATE \_\_\_\_\_

## Authorization for Emergency Medical Treatment Form

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ PHONE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 PHYSICIAN'S NAME: \_\_\_\_\_ PHONE \_\_\_\_\_  
 HEALTH INSURANCE COMPANY: \_\_\_\_\_ POLICY #: \_\_\_\_\_  
 ALLERGIES TO MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_  
 CURRENT MEDICATIONS: \_\_\_\_\_

In the event of an emergency, contact:

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

In the event that emergency medical aid/ treatment is required due to illness or injury during the process of receiving services, or while being on the TROT premises, I authorize TROT to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

### CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached. Emergency services from this area utilize Tucson Medical Center or St. Joseph's Hospital.

Other preference: \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

(Parent, or legal guardian, or legally competent adult rider over 21)

### NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/ aid in the case of illness or injury during the process of receiving services or while on the TROT premises.

Parent or legal guardian will remain on site at all times during equine assisted activities.

In the event that emergency treatment/ aid is required, I wish the following procedure to take place:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

(Parent, or legal guardian, or legally competent adult client over 21)

*\*This form must be updated annually*

**Physician's Referral Form**

A request has been made on behalf of \_\_\_\_\_ (patient name) for therapy at TROT Therapy Services (TTS), a pediatric outpatient clinic. TTS therapists utilize a variety of therapeutic treatment strategies including hippotherapy, treatment using equine movement. In order to provide this service, TTS requests that you complete this referral form.

Child's Height: \_\_\_\_\_ Weight \_\_\_\_\_

Please indicate if any of the following medical issues are present.

**ORTHOPEDIC – please circle yes or no and comment on YES answers**

1. Acute herniated disc - YES NO \_\_\_\_\_
2. Atlanto-axial instability- YES NO \_\_\_\_\_
3. Coxa Arthrosis- YES NO \_\_\_\_\_
4. Severe Osteoporosis- YES NO \_\_\_\_\_
5. Spondylolisthesis- YES NO \_\_\_\_\_
6. Spinal Fusion- YES NO \_\_\_\_\_
7. Pathological fractures- YES NO \_\_\_\_\_
8. Joint dislocation/subluxation- YES NO \_\_\_\_\_
9. Severe Kyphosis/Lordosis- YES NO \_\_\_\_\_

**NEUROLOGIC – please circle yes or no and comment on YES answers**

1. Shunt- YES NO \_\_\_\_\_
2. Seizures- YES NO; if yes, are they controlled by medication YES NO \_\_\_\_\_  
Seizure medication \_\_\_\_\_ date of last seizure \_\_\_\_\_
3. Spina Bifida- YES NO \_\_\_\_\_
4. Chiari II Malformation- YES NO \_\_\_\_\_
5. Tethered Cord- YES NO \_\_\_\_\_

**OTHER MEDICAL – please circle yes or no and comment on YES answers**

1. History of CVA - YES NO \_\_\_\_\_
2. History of PVD - YES NO \_\_\_\_\_
3. Cardiac Condition -YES NO \_\_\_\_\_
4. Other condition(s) not listed: \_\_\_\_\_  
\_\_\_\_\_

I have reviewed this referral form and refer this patient to TROT Therapy Services for evaluation and treatment that may include hippotherapy at the discretion of the treating therapist. Please indicate specific therapy(s) requested:

Occupational Therapy       Physical Therapy

This script will be good for one year.

Child's Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Diagnosis \_\_\_\_\_ Code \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Office Address \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_