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Date: ________________________________

Dear Health Care Provider:

Your patient, ____

(Participant's name)

has been participating in supervised equine activities at Simple Changes therapeutic riding center and is due for an update of their medical status. Please review their previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses, hospitalizations, changes in medications, treatment, weight, or behavior. **Please indicate current height/weight**. If this person has Down syndrome or any other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her neurologic exam.

Diagnosis: ____

Height: __________________ **Weight**: ___________________

Update Status: ____

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Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO NP PA Other ___________

Signature: ____ Date: ____________________

Address: ____

Phone: (_____)___________________________________ License/UPIN Number: ___________________________

Send completed form to: Simple Changes PO Box 991 Lorton, VA 22199 or fax 703.372.2625