



Xenophon Therapeutic Riding Center
P.O. Box 16 • Orinda • CA • 94563
(925) 377-0871



Patient Name: _____ DOB: _____

Diagnosis & ICD-9code: _____ Date of Onset: _____

Precautions: _____

Physician Referral

Medical History of Patient:

Surgical Procedures:

Hip X-Rays: Date of last X-Ray: _____ Subluxation Present? Yes _____ No _____

Seizures: Yes _____ No _____. If yes, are the seizures controlled with medication? _____

Medications:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Please list any pertinent information which you feel is relevant to the care of this patient for Physical or Occupational Therapy interventions:

Is there any information related to sensation, tone, vision, speech, circulation, audition or psychological symptoms which may help us to better understand this patient?

Statement of Referral

I have reviewed the contraindications for physical and occupational therapy and in my opinion, this patient can receive outpatient therapy at Xenophon TRC. It is my understanding that the evaluation and treatment of this patient will be under the direct supervision of a physical or occupational therapist.

Physician Signature: _____ Date: _____

Printed Name, Address, Phone, Fax (Physician Stamp will serve this purpose if available):

