

# TEAM Prescription

Client's Name \_\_\_\_\_ Phone \_\_\_\_\_

## Prescription for Therapeutic Horseback Riding

Prescription where appropriate for evaluation and treatment by a Physical, Occupational, and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Operating Center.

Recommended Frequency \_\_\_\_\_

Precautions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

*(Please print, type or stamp)*

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_