The Medicine Horse Center

Equine Assisted Therapies
P.O. Box 1074, Mancos, CO 81328
Tel: 970-533-7403 Fax: 970-533-7405

Instructions for Equine Assisted Psychotherapy Application

The following forms are to be filled out by the following persons:

Page 1 – Instructions

Page 2 – Client or Parent/Guardian

Page 3 – Client or Parent/Guardian

Page 4 – Client or Parent/Guardian

Page 5 – Client or Parent/Guardian

Page 6 – Client or Parent/Guardian. Co-Signature required by Client's Referring Therapist.

Page 7 – Client or Parent/Guardian

Page 8 – Client's Referring Therapist

Page 9 – Client's Referring Therapist

All forms must be completed in their entirety and submitted to the Medicine Horse Center prior to the first session.

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Participant's Registration and Release Form

Client:_____Date of Birth:_____ Weight:_____lbs

For the safety of our horses, there is a **client weight restriction of 180 lbs.**

Street:_____City:_____State:_____Zip:_____

Phone: Home:_____Work _____Emergency:_____

Parent/Guardian Name:_____

Address/Phone:_____

School or institution presently attending:_____

In case of emergency contact:_____Phone:_____

contact:_____Phone:_____

Photo Release

I hereby consent to and authorize the use and reproduction by The Medicine Horse Center of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature:_____ Date:_____

(Participant or Parent/Guardian)

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Participant Liability Release Agreement

I, _____(Client's Name) would like to participate in The Medicine Horse Center's Equine Assisted Therapy Programs. I acknowledge the risks and potential for risks of being around horses. However, I feel that the possible benefits to myself/ my child/ my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against The Medicine Horse Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in The Medicine Horse Center's Therapeutic Riding and Equine Rehabilitation Program.

UNDER COLORADO LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LAIBLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERANT RISKS OF EQUINE ACTIVITIES THAT ARE OBVIOUS AND NECESSARY, PURSUANT TO 13-21-119 COLORADO REVISED STATUES.

Signature:_____ Date:_____

(Participant or Parent/Guardian)

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Participant's Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize ***The Medicine Horse Center*** to:

_X_ Secure and retain medical treatment and transportation if needed.

_X_ Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment at my expense.

I hold the Medicine Horse Center harmless for any expenses incurred in my interests.

Name:_____ Phone:_____

Address:_____

Emergency Contact: _____ Phone: _____

Physician's Name and Phone:_____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Phone: _____

Policy #: _____ Group #: _____

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 below is unable to be reached.

Print Name: _____ Phone: _____

Address:_____

Consent Signature:_____ Date: _____

(Participant or Parent/Legal Guardian)

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 being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

_____

_____

Non-Consent Signature:_____ Date: _____
(Participant or Parent/Legal Guardian)

Print Name: _____ Phone:_____

Address:_____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.

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Equine Facilitated Psychotherapy
Consent for Release of Confidential Information

I, *(participant)*_____ hereby authorize and request that **The Medicine Horse Center** may discuss the following information with the following:
_____ (*please check all that apply*):

_____ Admission for treatment
_____ Psychiatric Evaluation
_____ Psychosocial Assessment
_____ Treatment Progress Notes
_____ Physician Orders
____ Diagnosis
____ Psychological testing results
____ Treatment Plan
____ Discharge Summary
____ Other _____

The purpose of this disclosure is for the development of an Equine Facilitated Psychotherapeutic plan and program. I understand that this authorization will remain in effect until _____ (*specify date which is not to exceed 12 months*).

This information will be released in the following format (*please check all that apply*):

_____Verbal Via Telephone _____Handcarried

_____Via Mail _____ Via Facsimile (Fax)

Pursuant to Federal Regulations, this information will not be forwarded to any other provider or agent.

_____ _____
Participant Date

_____ _____
Parent or Legal Guardian Date

_____ _____
Witness Date

_____ _____
Referring Therapist Date

_____
Address of Therapist

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Therapeutic and Safety Issues

Check and describe applicable issues (indicate current issues, or history of):

___ inattention
___ hyperactivity
___ lack of concentration
___ learning disabilities
___ developmentally delayed
___ mentally challenged
___ boundary issues
___ social skills problems
___ problem with peers
___ separation anxiety
___ anxiety
___ phobias
___ aggressive
___ history of assaulting others
___ manipulative
___ unpredictable or dangerous behavior
___ sensory impairment
___ sensitivity, preferences
___ tics or stereotypic behavior
___ psychosomatic symptoms
___ medical issues
___ self-injurious behavior
___ suicidal ideations
___ history of runaway
___ issues of parental support
___ issues of family support
___ sexual abuse/acting out
___ history of physical abuse
___ history of emotional abuse
___ hallucinations
___ delusions
___ illusions
___ dissociations
___ substance abuse problems
___ legal problems
___ school problems
___ history of animal abuse and/or fire setting
___ seizure disorder
___ possible medication side effects

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Mental Health Data Form

Client's Name: _____Age: _____ DOB: _____

Gender: M or F Height: _____ Weight: _____

Parent/Legal Guardian: _____

Phone: (H) _____ (W) _____ (C)_____

Address:_____City:_____State:_____Zip:_____

Physician: _____ Phone: _____

Therapist: _____Phone: _____

Diagnosis (DSM-IV)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Presenting Problems

_____

_____

_____

_____

Current Medications

Drug	Dose	Route	Time	Purpose

Mental Health Data Form (con't)

Psychiatric Treatment History

	Where	When	Diagnosis
Current Therapy			
Outpatient Therapy			
Inpatient Therapy			