Equine Assisted Activities
Educator and/or
Mental Health Provider Referral

Please give this form to the Educator and/or Mental Health Provider that the participant is working with on a regular basis. This information is required for our program and will remain confidential between our program staff and mental health specialist.

Client: _____ Age: _____ Date: _____

Diagnosis: _____

Name of provider _____

Provider Contact Email/Phone: _____/_____

Please answer the following in terms of goals/objectives etc. that you are striving to achieve with the participant.

How do you feel non-mounted Equine Assisted Activities can benefit this individual?

Short Term Goals:

Long Term Goals:

Other Objectives:

Limitations:

Area of Strength:

Precautions: