Medical Record Maintenance Compliance Form

I certify that I maintain the following records for each participant I treat at

(center name)

1. A prescription from a physician IF required by my practice act or local laws and regulations
2. A comprehensive written initial assessment including screening for precautions and contraindications
3. A written treatment plan that includes long- and short-term goals reflective of the type of therapy
4. Written progress notes, completed on a regular basis, that reflect the treatment and its modifications based on the response of the patient
5. Written periodic review, and re-evaluations completed on a regular basis that update the goals and treatment plan and make recommendations for further treatment, discharge or transition into another program

Printed Health Professional Name and Credentials

Health Professional Signature/Date
Equine-Facilitated Psychotherapy
Consent for Release of Confidential Information

I, ____________________________________________________, hereby authorize and request that
(client)

______________________________________________________ may release to
(mental health professional)

___________________________________________________________________________________
(center name)

the following information (please check the allowable information):

☐ Admission for Treatment
☐ Diagnosis
☐ Psychiatric Evaluation
☐ Psychological Testing Results
☐ Treatment Progress Notes
☐ Discharge Summary
☐ Physician Orders
☐ 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 (verbal per telephone, electronic, mail, hand-carried):

__________________________________________________________________________

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

_____________________________________________________________    ____________________
Client                                                                      Date

_____________________________________________________________    ____________________
Parent or Legal Guardian                                                         Date

_____________________________________________________________    ____________________
Witness                                                                         Date

_____________________________________________________________    ____________________
Referring Mental Health Professional                                Date

_____________________________________________________________    ____________________
Address of Mental Health Professional

PATH Intl. Standards for Certification & Accreditation
2018
Equine-Facilitated Psychotherapy
Referral Form

Client Name: ___________________________ DOB: ___________ Age: _________

Address: ___________________________________________________ Phone: _________________

Diagnosis: _________________________________________________________________________

Recommended Frequency and Duration of Sessions: ________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Type of Format:                  ___ Group Work          ___ Individual Work          _____ Family Work

Specific issues to address:

Current treatment goals:

Additional information:

_____________________________________________________________    ____________________

Mental Health Professional                                                Date

___________________________________________________________________________________

State Credentials/License #                            Phone & Fax Numbers

___________________________________________________________________________________

Address

Return to: (riding program’s name & address)

Thank You for Your Participation and Referral
Mental Health Data Form

Client’s Name: _______________________________________________________________________________________
Age: ___________ DOB: _______________ Sex: _____ Height: ___________ Weight: ___________
Parent/Legal Guardian: __________________________________ Phone: H _______________ W _______________
Address: ____________________________________________________________________________________________
Physician: __________________________________________________________ Phone: _____________________
Mental Health Professional: ________________________________________________ Phone: _____________________

Diagnosis (DSM-IV)
Axis I ______________________________________________________________________________________________
Axis II _____________________________________________________________________________________________
Axis III _____________________________________________________________________________________________
Axis IV _____________________________________________________________________________________________
Axis V _____________________________________________________________________________________________

Presenting Problems
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Current Medications
Drug Dose Route Time Purpose
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Psychiatric Treatment History
Current Therapy Where When Diagnosis
Outpatient Therapy
Inpatient Therapy
Therapeutic and Safety Issues

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

- inattention
- hyperactivity
- lack of concentration
- learning disabilities
- developmentally delayed
- cognitively challenged
- boundary issues
- social skills problems
- problems with peers
- separation anxiety
- anxiety
- phobias
- aggressive
- assaultive
- 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
- 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

____________________________________________________________________________________________________

Information Source                                                            Date Form Completed

Ideally this form is designed to be used in conjunction with the PATH Intl. Participant Medical History, Physician’s Statement and Physician’s Release Statement.
FOR PROVIDER OF THERAPY SERVICES

Consent for Treatment and Release of Liability

Mental Health Professional Name or Business Name

Address and Phone Number

*This is not a complete form and may not be photocopied. Each provider of therapy services must create their own form after obtaining legal counsel in order to include appropriate wording and content for particular state regulation and different treatment situations.

Samples of wording that may be included:

“No child can be accepted for therapy until all forms have been completed by the parent/guardian. If the patient is of legal age and mentally competent, he/she may complete the forms without parent’s or guardian’s signature.”

“Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by any of the organizations concerned, including (name of center or therapy practice/provider), its officers, trustees, agents, employees, each and every one of its members and associates, and the property owners upon whose land the therapy sessions are conducted.”

“I request and consent to treatment that may include therapy, and I have discussed this with my child’s doctor. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including (name of center or therapy practice/provider).”

Dated signatures of parent/guardian or client of legal age must be included.