



Trot On: Equine Therapy at JRI

Program Director:

Meredith Norton, MSW, LICSW, PATH CTRI

Please email completed referrals to: mnorton@jri.org



Information about individual being referred:	
Date of Referral:	Address:
Name of Person referred:	Telephone:
Date of birth:	Preferred Language:
Primary Insurance:	Policy #:
Secondary Insurance:	Policy #:
Racial Identity:	Gender Identity:
Ethnic Identity: <input type="checkbox"/> Latino/a/x or Hispanic <input type="checkbox"/> Not Latino/a/x or Hispanic <input type="checkbox"/> Decline to specify	

Guardian Information (please skip if person referred is own guardian)	
Name:	Physical custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to person:	Legal custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:	Telephone (cell):
Telephone (home):	Preferred Language:

Referral Source
Referral source name:
Relationship to person referred:
Telephone:

Additional Information
Please list any allergies:
Please list any medical conditions:
Please list medications and dosages:
Please list services in which individual is currently enrolled (i.e. outpatient therapy, in home therapy, in-home behavioral, psychiatry, therapeutic mentoring, etc.)
Please list current diagnoses:

Please list all individuals currently living in the home:		
Name:	DOB:	Relationship to person:
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Involvement with animals:
Please describe any previous or current involvement with horses or animals (including pets):
Any history of aggression towards animals? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past <input type="checkbox"/> Current If yes, please describe:
Service Preferences (check all that apply):
<input type="checkbox"/> Equine therapy with observation of equines (observation with minimal/no contact with the horses) <input type="checkbox"/> Equine therapy with unmounted (on the ground) activities (i.e. leading, grooming, caretaking) <input type="checkbox"/> Equine therapy with mounted (riding) activities
*Please note that preferences may not be guaranteed for mounted activities based on safety, inclement weather, and necessary adaptations to treatment interventions based on needs of the individual served and the horse(s) involved

Please list all that apply:	
DCF contact name:	Telephone:
DMH contact name:	Telephone:
Primary Care Physician:	Telephone:
Name of School:	School district/town:
School contact name:	Telephone:
Emergency contact name (other than guardian/primary caregiver):	Telephone: Relationship to person:

Why is this person in need of services at this time?
What are goals of treatment?