



Trot On at JRI

Psychotherapy with Equine Interaction

Program Director:
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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 check all that apply:		
<input type="checkbox"/> Current substance use <input type="checkbox"/> History of substance use Please describe:	<input type="checkbox"/> Family history of substance use	<input type="checkbox"/> Involvement with peer group that engages in substance use

Please list all individuals currently living in the home:		
Name:	DOB:	Relationship to person:
Name:	DOB:	Relationship to person:
Name:	DOB:	Relationship to person:

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"/> Therapy with observation of equines (observation with minimal/no contact with the horses) <input type="checkbox"/> Therapy with equine interaction on the ground (i.e. leading, grooming, caretaking) <input type="checkbox"/> Therapy with equine interaction while on the horse (riding)
<p>*Please note that preferences may not be guaranteed for any above activities based on safety, inclement weather, and necessary adaptations to treatment interventions based on needs of the individual served and the horse(s) involved. Sessions may include riding only infrequently and only if aligned with treatment goals. Sessions are primarily on the ground.</p>

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's causing them to seek services now?)

What are the goals of treatment? (What does the individual hope to gain from therapy?)