Psychotherapy with Equine Interaction

Program Director:
Meredith Norton, MSW, LICSW, PATH CTRI

Please email completed referrals to: mnorton@jri.org

About our services:
Please note that the service you are referring to is considered outpatient therapy, provided by a mental health practitioner. Our services do not include horseback riding. Therapy sessions include interactions with horses such as: caretaking for horses, learning to lead (walk alongside with lead rope), learning about horse body language, learning to communicate with horses, etc.

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: ☐ Latino/a/x or Hispanic ☐Not Latino/a/x or Hispanic ☐Decline to specify	

Guardian Information (please skip if person referred is own guardian)	
Name:	Physical custody? ☐ Yes ☐ No
Relationship to person:	Legal custody? ☐ Yes ☐ 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 check all that apply:		
☐ Current substance use ☐ History of substance use Please describe:	☐ Family history of substance use	☐ 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? ☐ Yes ☐ No ☐ Past ☐ Current If yes, please describe:

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?)