REFERRAL REPORT

Date: _______________

Dear Physician, Therapist, Social Worker, or other Helping Professional:

Your patient: _____________________________________ (participant's name) has expressed an interest in participating in a Cairns Psychological Services Animal-Assisted Therapy (AAT) program Cairns Psychological Services requires a current update of their medical/mental health status prior to participation in their program. Please review this patient's medical/mental health history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illness, hospitalizations, and changes in medications, treatment, weight, or behavior. Please indicate current height/weight. Included, for your reference, is a description of AAT programming (brochure). In addition, for your reference*, **potential precautions and contraindications*** for Cairns Psychological Services AAT programming are listed on the second page. Please review and comment on these as appropriate in your report.

Patient Diagnosis:____

Height: _____________ Weight: ____________________

Updated Status and Report:

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To my knowledge, there is no reason why this person cannot participate in a supervised Animal-Assisted Therapy (AAT) programming. However, I understand that Cairns Psychological Services will weigh the medical information listed above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed, credentialed health professional (e.g. Psychologist, Social worker, PT, OT, Speech Language Clinician, etc) in the implementations of an effective AAT program.

Name/Title: ____MD DO NP PA Other ________

Signature: ____ Date: ____________________

Address: ____
____

Phone: (   ) _____-___________ License/UPIN Number: ____

Precautions and Contraindications for
Animal-Assisted Therapy (AAT) Programs

Please note that the following conditions may suggest precautions and contraindications to AAT participation. Therefore, when completing this form, please note whether these are present, and to what degree.

MEDICAL

Allergies (animal & environment & food)
Autoimmune Conditions
Blood Pressure Control
Exacerbations of medical conditions
Heart conditions
Hemophilia
Migraines
PVD
Recent Surgeries
Respiratory Compromise

PSYCHOLOGICAL

Dangerous to self or others
Fire Setting
History of Animal Abuse
Physical/Sexual/Emotional Abuse Medical Instability
Substance abuse
Thought Control Disorders
Weight Control Disorder

ORTHOPEDIC

Atlantoaxial Instability (include neurologic symptoms)
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathological Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

NEUROLOGIC

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari 11 malformation/
Tethered Cord/Hydromyelia

OTHER

Age- Under 4 years
Indwelling Catheters
Medication – i.e. photosensitivity
Poor Endurance
Skin Breakdown