E. 1 EQUINE FACILITATED-PSYCHOTHERAPY-MENTAL HEALTH-THERAPIST

Equine Facilitated Psychotherapy
Consent for Release of Confidential Information

I, _____ hereby authorize and request that
(Client)

_____ may release to
(Therapist)

PEG'S THERAPEUTIC PONIES, INC.
1055 Wales Run
Mount Washington, KY. 40047
502-955-4152

The following information (please check the allowable information):

_ Admission for treatment
_ Psychiatric Evaluation
_ Psychosocial Assessment
_ Treatment Progress Notes
_ Physician Orders
_ Diagnosis
_ Psychological testing results
_ Treatment Plan
_ Discharge Summary
_ 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,, via 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 Therapist Date

_____
Address of Therapist

E. 2 EQUINE-FACILITATED-PSYCHOTHERAPY-MENTAL HEALTH-THERAPIST

MENTAL HEALTH DATA FORM

Client's Name: _____
Age: _____ DOB: _____ Sex: _____ Height: _____ Weight: _____

Parent/Legal Guardian: _____ Phone: H _____ W _____

Address: _____

Physician: _____ Phone: _____

Therapist: _____ 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			

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:

_____ _____

(Health Care Professional) (Date)

_____ _____

(State Credentials/License #) (Phone & Fax Numbers)

_____

(Address)

Return to: PEG'S THERAPEUTIC PONIES, INC

1055 WALES RUN

MOUNT WASHINGTON, KY 40047

Thank you for your participation and referral.