Crossroads Corral

Equine Assisted Learning & Growth

Equine Assisted Therapy Referral Form

Client Name:_____

DOB: _____ Age:_____ Phone:_____

Email:_____

If client is a minor, whom do we contact?

Name_____ Relationship:_____

Insurance Carrier:_____

Referred By:_____ Email:_____

Reason for Referral (Please briefly explain below)

Client consents to Crossroads Corral team contacting them regarding scheduling Equine Therapy

_____ YES _____NO

Client consents to the Crossroads Corral therapy team speaking with Referral regarding Equine Therapy and sessions

_____YES _____NO

_____ _____

Patient Signature (Age 12yrs. & older must sign) Date

_____ _____

Parent/Guardian Date

Please send completed referral form to Lindsay@Crossroadscorral.org

Crossroads Corral

Equine Assisted Learning & Growth

6879 S. Sylvan Lake Drive. Sanford, Fl. 32771 / 407-463-1208 / info@crossroadscorral.org / **www.CrossroadsCorral.org**