



LEAP

Lowcountry Equine-Assisted Psychotherapy

Referral for LEAP Services (Please Print)

Date _____

Patient's Name _____

Age _____ Date of Birth _____ Sex _____

Home Address _____

Parent/Legal Guardian _____

Phone: Home _____ Cell _____ Work _____

Referred by _____

Relationship to patient _____

Phone: _____

Fax: _____

Reason for Referral/Goals for Treatment
