



# AMERICAN ENDURANCE RIDE CONFERENCE

## Post Ride RIDER Survey Form

Thank you for taking time to provide this important information!

Please complete this form ONLY if your horse experienced any lameness or metabolic problems related to the ride whether at the ride site or after leaving. Please be thorough to the best of your knowledge and use the back of this sheet if necessary for comments. You can remain anonymous or include your name, but please respond. Return completed form to the National Office by mail, e-mail, or fax as noted at the bottom of this form.

Ride Name: \_\_\_\_\_ Ride Date: \_\_\_\_\_ Region: \_\_\_\_\_

Ride Length: \_\_\_\_\_ Were there sufficient control judges? Yes \_\_\_ No \_\_\_ Total hold time (hours) \_\_\_\_\_

Time to Finish \_\_\_\_\_ Placing \_\_\_\_\_ Total Riders \_\_\_\_\_ Total Control Judges \_\_\_\_\_ Number of Control Checks \_\_\_\_\_

Did you finish this ride? Yes \_\_\_ No \_\_\_ Please rate difficulty of ride using scale of 1-10 (10 most difficult) \_\_\_\_\_

Briefly discuss weather conditions: \_\_\_\_\_

Horse Info: Age \_\_\_\_\_ Sex \_\_\_\_\_ Years competing \_\_\_\_\_ Lifetime mileage \_\_\_\_\_

Rider Info: Age \_\_\_\_\_ Sex \_\_\_\_\_ Years competing \_\_\_\_\_ Lifetime mileage \_\_\_\_\_

**Reason for Failure to Finish:**

Lameness – Be specific, i.e., location, diagnosis, for example “sore RF suspensory”): \_\_\_\_\_

\_\_\_\_\_ When? \_\_\_\_\_ (miles)

Metabolic: Tying up \_\_\_\_\_ When? \_\_\_\_\_ (miles)

Failed to recover \_\_\_\_\_ Pulse \_\_\_\_\_ CRI \_\_\_\_\_ When? \_\_\_\_\_ (miles)

Colic \_\_\_\_\_ When? \_\_\_\_\_ (miles)

Other \_\_\_\_\_ When? \_\_\_\_\_ (miles)

Was treatment required for any of the above conditions? Yes \_\_\_ No \_\_\_ In your opinion was the control judge/ treatment vet staff competent and prepared (equipment, supplies, etc.) to handle treatment? Yes \_\_\_ No \_\_\_

Comments \_\_\_\_\_

Did this horse require treatment within 72 hours of ride for a condition not observed or treated at the ride?

Yes \_\_\_ No \_\_\_ If yes, for what diagnosis? \_\_\_\_\_

Did you continue treatment at home or at a referral clinic? Yes \_\_\_ No \_\_\_ If yes, list specific details:

Nasogastric tube: Yes \_\_\_ No \_\_\_ If yes, with what? \_\_\_\_\_

Intravenous fluids: Yes \_\_\_ No \_\_\_ If yes, quantity in liters? \_\_\_\_\_

Medications: \_\_\_\_\_

Duration of treatment: \_\_\_\_\_ Has the problem resolved? Yes \_\_\_ No \_\_\_

Opinion as to recovery and future ability to compete on this horse: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Had any of the problems associated with this ride been observed in this horse previously? Yes \_\_\_ No \_\_\_

If yes, please detail (dates, etc.): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_