St. Mary's Ryken
A College Preparatory Catholic High School

Athletic Injury Referral Form

Athlete Name: _____ Sport: _____

Date of Office Exam: _____ Date of Injury _____

TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

TREATMENT

Modalities

_____ Ice _____ Cold Whirlpool _____ Warm Whirlpool

_____ Moist Heat _____ E Stim _____ Ultrasound

Exercises

_____ ROM _____ Stretching _____ Strengthening

_____ Sports Specific _____ Graduated RTP

Any other specific treatments or exercises not listed: _____

_____

_____ Permission for ATC to re-evaluate and modify treatment as needed

PARTICIPATION STATUS:

_____ No participation until follow-up on _____

_____ May return to participation without follow up when ATC deems acceptable

_____ May return to play on this date: _____

_____ May return to play with these restrictions: _____

_____

_____ May return to full participation no restrictions

Physician Stamp

_____

Printed Physician Name

_____

Physician Signature Date Phone Number