SOUTH KITSAP ATHLETIC MEDICINE REFERRAL TO A HEALTH CARE PROVIDOR FOR EVALUATION OF CONCUSSION/HEAD INJURY SYMPTOMS

DATE: _____

TO: Washington-Licensed Health Care Provider

FROM: _____, LAT, ATC

RE: Student Name: _____ Birthdate: _____
School: _____ Grade: _____

I, the parent/guarding authorize release of information about concussion and management, between this school and student's physicians:

Name: _____ _____
(Signature of Parent or Guardian) (Printed Name of Parent or Guardian)

Dear Licensed Health Care Provider:

This student-athlete was noted to have these symptoms or signs after an injury (either immediately or minutes/hours after):

[ ] Headache or pressure feeling in head [ ] Nausea [ ] Vomiting [ ] Confusion/foggy feeling
[ ] Concentration/memory problems [ ] Ringing in ears [ ] Dizziness or "seeing stars"
[ ] Delayed response to questions [ ] Light or noise sensitive [ ] Appeared dazed
[ ] Amnesia around event [ ] Slurred speech [ ] Fatigue [ ] Temporary loss of consciousness
[ ] Irritability or personality change [ ] Standardized Concussion Assessment (SCAT3) attached

The injury occurred on _____ (date) at approximately _____ (time).
Details of injury occurred are (i.e. which sport/activity, part of the head or body hit, nature of object, force, etc):

_____

_____

Witness(es) to the injury and/or signs/symptoms of were (check all that apply):
[ ] Staff members (names and locations): _____
[ ] Fellow athletes (no names) [ ] Injured athlete's self-report [ ] Injured athlete's parent/guardian
[ ] Other _____

Input regarding the medical examination today and medical management plans are requested by the South Kitsap High School Athletic Medicine department. Attached is a: [ ] Return to Learn for you to complete

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<u>To be completed by examining health care provider:</u> I have reviewed the above history of concussion symptoms and concur that a concussion occurred or is likely to have occurred and I prescribe the following:

[ ] <u>Recommended standard for initial treatment:</u> start the REBRAIN protocol and allow the licensed athletic trainer to proceed with return-to-learn and return-to-play protocols.

[ ] Start Return-to-Play Protocol under the direction of a licensed athletic trainer

[ ] Physician Recommended School Accommodations

[ ] I follow this patient myself or [ ] Patient to be followed by: _____ (*Name of primary care doctor or specialist)*

PLEASE return this form to:

Printed Name: _____

South Kitsap High School Athletic Medicine Department
425 Mitchell Ave, Port Orchard, WA 98366
Tel: _____ FAX: 360-874-5892

_____ _____
Signature of Examining Clinician *Date*

_____
Printed Name of Examining Clinician

_____
Telephone No.

_____
Name of Clinic / Address of Clinician