# Physician Referral Form

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Today's Date:______________ Date Injured:_______________

**Name:**___________________________________ **Sport:**_____________________________

**Injury/Illness:**_____________________________________________________________________________

**DIAGNOSIS:**_______________________________________________________________________________

**Please fill out a definitive diagnosis; we are required to have this for our records**

## TO BE COMPLETED BY PHYSICIAN

☐ **Permission for the Certified Athletic Trainer to evaluate and treat as needed**

## Rehabilitative Therapy

***The following treatments can be conducted in our Athletic Training Facility. Please check the treatment and/or exercise to aid in the rehabilitative process. If a specific protocol is warranted (i.e. ACL protocol, UE protocol) please include that protocol for the Athletic Trainer to follow.**

### MODALITIES

☐Ice-Compression-Elevation
☐Cold Whirlpool
☐Ice Massage
☐Moist Heat
☐Warm Whirlpool
☐Ice Bath
☐ESTIM (TENS/NMES)
☐Crutches- NWB PWB

### Exercises

☐Passive ROM
☐Active-Assistive ROM
☐Active ROM
☐Closed Chain Ex.
☐Stretching Ex.
☐Progressive Resistive Ex.
☐Core Stability

Comments:_________________________________________________________________________________

___________________________________________________________________________________________

## Return to Participation Criteria

☐Must see physician before returning to participation
☐May return to participation without physician recheck upon:

a. Ability to perform pain free ROM and strength tests
b. Ability to perform sport specific tests determined by Athletic Trainer(s)

☐May return to participation on this date:_________________________________
☐May return to participation immediately

______________________________ ________________
Physician Signature Date

______________________________ ________________________
Physician's Printed Name Physician's Office Telephone #