ATHLETIC INJURY REFERRAL DEMATHA CATHOLIC HIGH SCHOOL

Wendy Norris MS, LAT, ATC
Phone (240) 764-2253 Fax (240)764-2278

Referral Date: _____ Injury Date: _____

Athlete Name: _____ Sport: _____

TO BE COMPLETED BY PHYSICIAN ONLY

DIAGNOSIS: _____

RECOMMENDED MODALITIES:

- ❑ Ice
- ❑ Moist Heat
- ❑ E Stim
- ❑ Cold Whirlpool
- ❑ Hot Whirlpool
- ❑ Ultrasound
- ❑ Ice Massage
- ❑ Contrast Bath
- ❑ Laser

EXERCISES:

- ❑ Passive ROM
- ❑ Active ROM
- ❑ Active-Assistive ROM
- ❑ Stretching
- ❑ Cardio
- ❑ Strengthening

Comments:

_____

_____

- ❑ Permission for ATC to re-evaluate and modify tx as needed

PARTICIPATION STATUS:

- ❑ May return to full participation immediately
- ❑ May return on this date: _____
- ❑ No participation till follow-up on: _____
- ❑ May return to participation without follow-up upon:
  - ❑ Full pain-free ROM
  - ❑ Comparable collateral strength
  - ❑ Ability to perform sport specific movements
- ❑ Restricted participation with these conditions:

  _____

Physician Name Printed _____ Date _____

Physician Signature _____ Phone _____