



Physicians: Please Return to Certified Athletic Trainer

Physician Diagnosis & Referral for Treatment

Fax: \_\_\_\_\_

Certified Athletic Trainer: \_\_\_\_\_ School: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

.....  
Athlete: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Injured Area: \_\_\_\_\_ Mechanism: \_\_\_\_\_

Assessment: \_\_\_\_\_ Treatment: \_\_\_\_\_

Referral For: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

.....  
Patient: \_\_\_\_\_ Date Seen: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Activity Level:

Weight Bearing Status:

- \_\_\_\_\_ Full Contact / Full Go
- \_\_\_\_\_ Non-Contact Vigorous
- \_\_\_\_\_ Non-Contact Light

- \_\_\_\_\_ No Participation for \_\_\_\_\_ days
- \_\_\_\_\_ No Participation
- \_\_\_\_\_ As Tolerated

- \_\_\_\_\_ NWB
- \_\_\_\_\_ PWB
- \_\_\_\_\_ FWB

Restrictions: \_\_\_\_\_

Prescription for certified athletic trainer to treat injury in athletic training room:

Modalities:

Exercises / Treatment:

- |                   |  |                                |
|-------------------|--|--------------------------------|
| _____ Hot Pack    | _____ ROM / Flexibility/Stretching               | _____ Rehabilitative Exercises |
| _____ Cold Pack   | _____ Ankle Rehabilitation/Strengthening Program | _____ Splints/Padding/Bracing  |
| _____ Ice Massage | _____ Gait Training                              | _____ Agilities                |
| _____ Wound Care  | _____ Rotator Cuff Strengthening Program         | _____ Other                    |
|                   | _____ Back Stretching/Stabilization Program      | _____ As Indicated             |
|                   | _____ Knee Rehabilitation Program                |                                |

Frequency: \_\_\_\_\_

Comments: \_\_\_\_\_

Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

