ATHLETIC INJURY REFERRAL
MARIETTA HIGH SCHOOL

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Jeff Hopp, LAT, ATC **Amanda Leon, MS, LAT, ATC** **Olivia King, MS, LAT, ATC, NREMT**

Referral Date: _____ Injury Date:_____

Athlete Name: _____ Sport:_____

TO BE COMPLETED BY PHYSICIAN ONLY

DIAGNOSIS:_____

Evaluate and Treat as indicated (check specific modalities and treatments if desired)

☐ Permission for ATC to evaluate and treat as needed

MODALITIES:

☐ Ice / Ice Massage ☐ Moist Heat ☐ E-Stim

☐ Ultrasound ☐ Other (explain below)

EXERCISES:

☐ Passive ROM ☐ Active ROM ☐ Cardio ☐ Manual Therapy

☐ Active-Assistive ROM ☐ Stretching ☐ PRE

Please explain any specific Tx not listed:

PARTICIPATION STATUS:

☐ No participation until follow-up on: _____

☐ May return to participation without follow-up upon:
a. Full pain-free ROM
b. Comparable collateral strength
c. Ability to perform sports specific movements

☐ May return on this date: _____

☐ Restricted participation with these conditions:

☐ May return to full participation immediately

_____ _____
Physician Printed Date

_____ _____
Physician Signature Phone #