MD REFERRAL FORM FOR ATHLETE ILLNESS / INJURY

NAME: _____ **DOB:** _____ **DATE:** _____
SPORT / LEVEL: _____ **SCHOOL:** _____
INJURY/ILLNESS _____ **INJURY DATE** _____
COMMENTS: _____
_____
_____

SECTION BELOW TO BE COMPLETED BY ATHLETE'S PHYSICIAN (MD / DO)

DX: _____

XRAY / MRI / OTHER RESULTS: _____

ACTIVITY LEVEL: (please check one)

☐ RETURN TO FULL PARTICIPATION (No Restrictions)

☐ LIMITED PARTICIPATION (Describe below) UNTIL RE-EVALUATED:
RESTRICTIONS / ACTIVITY LIMITATIONS: _____
_____
_____

☐ NO PARTICIPATION UNTIL RE-EVALUATED

ANY TREATMENT RECOMMENDATIONS? _____
_____

_____ _____ _____
PARENT/GUARDIAN SIGNATURE **NAME** **DATE**

_____ _____ _____
PHYSICIAN NAME (PRINT) **PHYSICIAN SIGNATURE** **DATE**
(or physician stamp)

Please contact me with any questions/concerns. Thank you!

_____ _____ _____
Athletic Trainer Name, Credentials e-mail Tel No.