Return to: _____
School: _____
Phone #: _____
Fax #: _____

PHYSICIAN RESPONSE FORM

To be completed by the attending physician

Patient name:_____ Date of Referral: _____

Reason for referral: _____

Physician name: _____ Date of Consult: _____

Practice Name: _____
Physician address (please use stamp):

Physician signature:_____

Diagnosis (please be specific): _____

_____

____ Please call physician's office for further instructions

Participation Status:
____ **No Restrictions** ____ **No Participation**

____ **Limited Participation** (Please explain): _____

Adaptive Equipment Suggestions: _____

Expected Date for Full Participation: _____

Follow up in office required: ___Yes ___No ___ As needed Comments: _____

Treatment:
____ Treat as needed (ATC's discretion)
____ Rehabilitation to be performed in athletic training room
____ Referred to physical therapy Duration of prescription: _____
____ Please contact physical therapist to coordinate treatment protocols

Special Instructions: _____
____ Treat as indicated: ____ Range of motion exercises ____ Heat
____ Functional, progressive exercise program ____ Ice
____ Functional testing ____ Strength exercises
____ Electrical Stimulation ____ Ultra Sound

Restrictions: _____
_____