HEAD INJURY REFERRAL FORM

Athlete's Name: ______________________________
Date of Referral: ______________________________
School: ______________________________
Date of Injury: ______________________________
Athletic Trainer: ______________________________
Sport: ______________________________
Clinical Impression of Injury: ______________________________
Comments: ______________________________

**Please complete the bottom portion of this form and return to Athletic Trainer to ensure that this athlete will receive the care that you have prescribed. This will become a part of the student's permanent medical record.

Respectfully,

____
Certified Athletic Trainer
NovaCare, Inc. Outpatient Rehabilitation

MEDICAL PROVIDER'S REPORT

Diagnosis:

____

Vestibular Rehabilitation Referral Indicated: Y / N

MEDICAL PROVIDER'S RECOMMENDATIONS

Academics

_____ May return to school at this time
_____ May return to school on ____ / ____ / ____
_____ No school until follow up appointment on ____ / ____ / ____

Please check any of the following supports:

_____ Shortened day (____ hours)
_____ Shortened classes (____ minutes max)
_____ Rest breaks as needed
_____ Allow extra time for test and assignments
_______ Lessen computer time
_______ No Classroom or Standardized Testing
_______ Other (please explain)
____

Athletics & Physical Education

_____ Do NOT return to sports practice/competition or Physical Education at this time
_____ May start RTP progression under the supervision of Athletic Trainer before returning to sport or Physical Education
_____ Must return to medical provider for full clearance to return to competition or Physical Education participation
_____ Has completed RTP progression w/o any recurrence of symptoms and is cleared for full participation

Comments: ____

Physician's Name/Signature: ______________________________________

Student-Athletes—Don't forget to return this form to the Athletic Trainers!! Thank You