MEDICAL REFERRAL

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

PHYSICIAN'S REPORT

Diagnosis:
____

Rehabilitation Referral Indicated: Y / N

Clearance Status:
______ May return to participation on ________________________
______ May not return to participation until further notice.
______ May return to participation at the discretion of the Athletic Trainer.
______ May return to participation with the following restrictions:
____

Comments: ____________________

Physician's Name: ____

Physician's Signature: ______________________________________

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