



Return to: \_\_\_\_\_  
School: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_

**PHYSICIAN RESPONSE FORM**  
To be completed by the attending physician

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

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:* \_\_\_\_\_

---

*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
  - \_\_\_\_\_ Functional, progressive exercise program
  - \_\_\_\_\_ Functional testing
  - \_\_\_\_\_ Heat
  - \_\_\_\_\_ Ice
  - \_\_\_\_\_ Strength exercises

*Restrictions:* \_\_\_\_\_

\_\_\_\_\_