Crater High School Sports Medicine

Physician Medical Referral/ Report Sam Drewes, MS, ATC

Cell: 218-368-9160

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Athletic trainers’ Impression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize release of the health care practitioners’ exam findings and other pertinent medical data of this injury/ illness as it relates to the participation of my child in Crater High School sports activities. I understand that the documentation of this injury/ illness will be kept on file in the Crater High School Sports Medicine Department.

Parent/ Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Recommended Treatment Protocol:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_ Evaluate/ Treat as needed  \_\_\_\_\_ Supportive Tape/Wrap/Brace  \_\_\_\_\_ Hot/Cold Pack  \_\_\_\_\_ Contrast Bath  \_\_\_\_\_ Ultrasound  \_\_\_\_\_ Electrical Stimulation | \_\_\_\_\_ AROM  \_\_\_\_\_ PROM  \_\_\_\_\_ Massage/ Effleurage  \_\_\_\_\_ Stationary Bike  \_\_\_\_\_ PNF Stretching  \_\_\_\_\_ Joint Mobilization | \_\_\_\_\_ Active Release  \_\_\_\_\_ LE Strengthening  \_\_\_\_\_ UE Strengthening  \_\_\_\_\_ Core Strengthening  \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_ Instrument Assisted Soft Tissue Mobilization | | |

Frequency of Treatment: \_\_\_\_\_PRN \_\_\_\_\_ Daily \_\_\_\_\_ 3X \_\_\_\_\_ 2X \_\_\_\_\_1X per wk

Recommended Participation Level:

\_\_ Full- unrestricted \_\_ Limited Practice w/ Restrictions \_\_ NO Participation

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participation Status:

\_\_\_\_\_ Athlete may return to full activity after passing functional testing by certified athletic trainer.

\_\_\_\_\_ Athlete may return on approximately \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

\_\_\_\_\_ Athlete may return only after my next examination set for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Physician Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_