



OLSH Athletic Training

Name: _____ Sport: _____

Date of Birth: _____ Date of Injury: _____

Parent/Guardian: _____

Phone: (H) _____ (W) _____ (C) _____

Family Physician: _____ Office #: _____

Assessment:

Referring ATC: _____ Date: _____

For Physician's Use Only!
***Physician Referral for Athletic Training Services**

Diagnosis: _____

Treatment Plan of Care: _____ X/WK for _____ WK(S). _____

Playing Status: NO RESTRICTIONS NON-CONTACT
 OUT for ____ DAYS ____ WKS Dr. VISIT FOR RELEASE
 MAY PARTICIPATE WITH TAPING/BRACING/PADDING
 SPECIAL INSTRUCTIONS: _____

FOLLOW UP: UNNECESSARY AS NEEDED M/D/Y: _____