Homewood-Flossmoor High School Sports Medicine Referral Form

Phone: (708) 799-3000 x5688   Fax: (708) 799-8292

TO: **Physician**

FROM: **Steve Szymkowiak, M.A., ATC, CSCS**
Brad Kleine, ATC, PES, CKTP
Matt Zalewski, ATC

______________________________ **is being referred for further evaluation and treatment. Please indicate**
(ATHLETE'S NAME/SPORT) **below the injury diagnosis and treatment prescription for ATC.**

Physician Diagnosis____

Physician Treatment____

____

Check the treatment(s) to be administered by the Certified Athletic Trainers:

___ Ice (cold packs/whirlpool)   ___ Heat (hot packs/whirlpool/contrast)   ___ Ultrasound

___ Therapeutic Exercise   ___ Electrical Stimulation   ___ Joint Mobilization
-Strength/Endurance
-ROM/Flexibility

___ Per ATC discretion   ___ Other (please specify) ___________________________________

INDICATE TOLERATED ACTIVITIES (Legal necessity for clearance):

- ❑ No Restrictions (full practice and competition participation)
- ❑ Participate as tolerated (ATC oversees athlete under physician's orders)
- ❑ Limited activity w/ following restrictions

  ___ No Contact   ___ Limited/Controlled Contact   ___ Limited mobility/cutting

  ___ Other (please specify): ____

- ❑ No Participation at this time

DATE OF RETURN TO PLAY (COMPETITION)_________________

Physician Name (Print) ______________________________

Physician Signature___________________________________ Date_____________

NOTE: Please attach a business card to this form so that we can contact your office if necessary.
Thank you in advance for your cooperation and assistance.