Physician Evaluation Form

This form is to be completed by the physician and returned to the athletic training office

Athlete's Name: Date:

Sport: Reason for Referral:

Physician's Diagnosis: _____

Treatment: The following treatments may be utilized in the rehabilitation of the above athlete.

Cold Therapy	Range of Motion Exercises
Cold Whirlpool	Resistive Exercises (bands, light weight)
Hydrocollator (moist heat packs)	Therapeutic Exercise
Electrical Stimulation	Cardiovascular Exercise (bike, elliptical)
Ultrasound	

Please list any treatments/exercises to be <u>avoided</u> during the treatment process:

_____

_____

Specific Instructions:

_____

_____

Return to Activity and PE:

____ The athlete may return to activity and PE on the following date: _____

____ The athlete may return to activity and PE at the discretion of the athletic trainer

____ The athlete may not return to activity and PE at this time

Follow-up appointment date: _____

____ The athlete does not need a follow-up appointment

Physician's Name/Address/Phone Number (please print)

_____

_____

_____

Physician's Signature: _____ Date: _____

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