hayashida & assoc
physical therapy, inc.

Bishop Diego Garcia High School

Physician Referral Form
To be completed by attending physician

Athlete's Name___________________________________ Date: ____________________________

Reason for referral: ____

____

Physician's Diagnosis (please be specific): ____

Participation Status:

_____No Restrictions _____No Participation
_____Limited Participation (Please explain): ____

____

Adaptive Suggestions: ____

Expected Date for Full Participation: ____

Treatment:

_____ *Treat as needed (ATC's discretion)*

_____*Rehabilitation to be performed in athletic training room*

_____ Range of Motion Exercises _____ Heat
_____ Functional, Progressive Exercise Program _____ Ice
_____ Functional Testing _____ Strengthening Exercises

_____ Referred to physical therapy Duration of prescription: _________________________________

Special Instructions/ Restrictions: ____

____

Physician's Signature: ____ Date: _______________________

Physician's Name: ____ Phone: _____________________

If you have any questions or comments, please contact Kristy Lash, the Bishop Diego High School Certified Athletic Trainer. Cell phone: (512) 680-7408. Hayashida & Associates Physical Therapy: (805) 685-1755.