

Bishop Diego Garcia High School

Physician Response 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 Equipment 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 Strength Exercises
 Referred to physical therapy Duration of prescription: _____

Special Instructions/Restrictions: _____

Physician's Signature: _____ Date: _____

Physician's Name: _____ Phone: _____

Please contact me, Brian Tuohy, the Bishop Diego Certified Athletic Trainer if you have any questions. Cell phone: 805-705-9715. Elite Performance & Rehabilitation Center: 805-681-9108