



# Westwood High School Warrior Sports Medicine

12400 Mellow Meadow  
Austin, TX 78750  
Fax: (512) 464-4030



## Physicians Referral

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Sport/Activity: \_\_\_\_\_

This student has been seen in the Training Room with: \_\_\_\_\_

## To Be Filled Out By Parent / Guardian

I \_\_\_\_\_ give \_\_\_\_\_ permission to release medical information for  
Parent/Guardian Name (print) Physician &/or Clinic Name  
\_\_\_\_\_ related to his/her \_\_\_\_\_ injury/illness to become a confidential  
Athlete Name Injury/Illness  
record of the Westwood High School Sports Medicine Department. \_\_\_\_\_  
Parent/Guardian Signature Date

Please provide the following information so this individual may be treated according to your instructions.

Diagnosis: \_\_\_\_\_

RECOMMENDED ACTIVITY	RECOMMENDED THERAPY (check all that apply)
<input type="checkbox"/> Complete Rest _____ Weeks _____ Days	<input type="checkbox"/> Cold / Hot Whirlpool <input type="checkbox"/> Flexibility / ROM
<input type="checkbox"/> Non-contact workout _____ Weeks _____ Days	<input type="checkbox"/> Contrast Bath <input type="checkbox"/> Bike
<input type="checkbox"/> Full contact WITH restrictions: _____	<input type="checkbox"/> Ice <input type="checkbox"/> Jog / Run
_____	<input type="checkbox"/> Moist Heat <input type="checkbox"/> Agility Drills
_____	<input type="checkbox"/> Jobst Cold Compression <input type="checkbox"/> Lower Body Workout
_____	<input type="checkbox"/> Muscle Stimulation <input type="checkbox"/> Upper Body Workout
<input type="checkbox"/> Full contact NO restrictions	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Tape/Brace
<input type="checkbox"/> Release to Athletic Trainer / Treat as needed	<input type="checkbox"/> Combination (US/Stim.) <input type="checkbox"/> Progressive Resistive Exercise
	<input type="checkbox"/> Other: _____

Any Special Instructions/Limitations: \_\_\_\_\_

Date of next appointment (if necessary): \_\_\_\_\_ Office Phone #: \_\_\_\_\_

Printed name of physician/stamp: \_\_\_\_\_ Fax #: \_\_\_\_\_

Signature of physician: \_\_\_\_\_

*Please return this form with the student, or by fax, as they will be unable to participate without the completed form.*

Thank You,

Greg Bauer, ATC, LAT  
Athletic Trainer  
Office: 512-464-4053  
Cell: 512-694-8391

Monica Matocha, ATC, LAT  
Athletic Trainer  
Office: 512-464-4120  
Cell: 512-284-0139

ATTENTION PARENT / STUDENT:

**YOU MAY NOT BE ALLOWED TO PARTICIPATE WITHOUT THIS FORM COMPLETE AND ON FILE WITH THE SPORTS MEDICINE DEPARTMENT**

White – Athletic Trainer Copy

Yellow – Parent Copy

Pink – Physician Copy