CHRISTUS SANTA ROSA
Sports Medicine

Injury Referral Note

Patient Name: _____
(Last) *(First)* *(Middle Initial)*

Date of Birth: _____ Gender: ☐ Male ☐ Female Current Age: _____

Injury: _____ ☐ Right ☐ Left Date of Injury: _____

Sport: _____ Location: _____

School: _____ District: _____

Name of Coach/Athletic Trainer: _____

Phone Number: _____

Parent/Guardian Name: _____ Relationship: _____

Phone Number: _____

History and Physical Findings (to be completed by Coach/Athletic Trainer): _____

Significant Past History: _____

Assessment (to be Completed by Physician): _____

Plan: _____

Activity: ☐ Return to Play ☐ Sent to ED with parent/guardian ☐ Referred to Physician

☐ Return to play with restrictions: _____

Athletic Trainer Certified/Licensed Athletic Trainer Printed Name:

_____ Date: _____

Athletic Trainer Certified/Licensed Athletic Trainer Signature:

_____ Date: _____

Trainer keeps the pink copy, athlete returns the yellow copy to the Trainer, Doctor keeps the white copy.