Lourdes Sports Medicine
Medical Referral Form for Concussed Athlete

(To be filled out by Athletic Trainer or School Nurse)

Name:_____ Grade:_____ Age:_____ Schoool:_____
Date of Concussion: _____Sport: _____Level: Vars JV Modified Youth

Concussion History: Date(s) of Previously known Concussion(s):_____
Mechanism of Injury for Current Concussion:

_____

_____

Treatment:
Removed from participation ____ Parent Notified ____ Referral to ER ____
Graded Symptom Check list ____ Cognitive Assessment ____ Postural Assessment ____

Certified Athletic Trainer: _____ Phone: _____

Dear Physician,
Please review and complete this form and have the athlete return to me.
The purpose of this form is to ensure that the athlete returns to play in a safe and appropriate manner as directed by the most recent medical evidence. Please contact me if you have any questions (phone number above).
For further information on concussions in young athletes please refer to:
Consensus Statement on Concussion in Sport. Clin J Sports Med 2009;19:185-200.

Return to Activity Plan: (Consensus State 2009 and National Federation of High School Athletic Associations 2010)
Step 1. Complete cognitive rest. This may include staying home from school or limiting school hours (and studying) for several days, which would be determined by a physician, or certified athletic trainer and supported by school administration. Activities requiring concentration and attention may worsen symptoms and delay recovery.
Step 2. Return to school full-time.
Steps 3-7 will be supervised by the Certified Athletic Trainer at the high school
Step 3. Light exercise. This step cannot begin until athlete is cleared by the treating physician for further activity. At this point the student athlete may begin walking or riding a stationary bike.
Step 4. Running in the gym or on the field. No helmet or other equipment.
Step 5. Non-contact training drills in full equipment. Weight training can begin.
Step 6. Full contact practice or training.
Step 7. Play in game.

Please indicate Level of Clearance (To be filled out by Physician)

_____ **Cognitive and Physical Rest Only** Limit school attendance, computer, TV, and Phone/Texting time.
_____**Cleared to Return to School with NO Physical Activity**. NO physical education class or athletics
_____**Follow up Appointment scheduled**

_____**Cleared to begin "Return to Activity Plan** (see above)

PHYSICIAN'S NAME:_____ Phone:_____

PHYSICIAN'S SIGNATURE_____ Date:_____