PRIME
SPORTS INSTITUTE

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Hours: Monday - Friday, 9am - 6pm
Phone 360-922-3120 Fax 360-504-0086

Name _____

DOB _____ Diagnosis (ICD-10) _____

Comments/Precautions/Goals _____

(Check any/all as appropriate)

- ❒ **Neck & Back Pain**
- ❒ **TMJ dysfunction**
- ❒ **Headache**
- ❒ **Upper Back Pain**
- ❒ **Shoulder Rotator Cuff Impingement**
- ❒ **Post-Operative Orthopedic Rehabilitation**
- ❒ **Sports and Dance Injury**
- ❒ **The First Year of Childbirth**
- ❒ **Motor Vehicle Injury**
- ❒ **Foot/Ankle Injury**
- ❒ **Hip Injury**
- ❒ **Elbow Injury**
- ❒ **Sprain and Strain**
- ❒ **L&I**

Treatment Services Offered (check any/all as appropriate)

- ❏ Evaluate and treat per AT discretion
- ❏ Passive/Active ROM
- ❏ Therapeutic Exercise
- ❏ Stretching/Flexibility Techniques
- ❏ Proprioceptive Neuromuscular Facilitation (PNF)
- ❏ Myofascial Release
- ❏ Soft Tissue and Joint Mobilization
- ❏ Progressive Resistive Exercise
- ❏ Sports Injury Prevention Program
- ❏ Return to Sports Functional Training
- ❏ Balance/Proprioception
- ❏ Neuromuscular Re-education
- ❏ Dynamic Back/Neck Stabilization
- ❏ Home Exercise Program
- ❏ Posture Retraining
- ❏ Biomechanics of Bending and Lifting
- ❏ Orthopedic Sport Screen
- ❏ Massage Therapy
- ❏ Other _____

Frequency: 1x/wk 2x/wk 3x/wk Other **Duration**: 2 weeks 3 weeks 4 weeks Other

Health Care Provider Signature (required) _____ **Date** _____

In making this referral, HCP certifies that athletic training services are a medical necessity.

Health Care Provider Name (print) _____

Office Telephone _____