Hawaii State Department of Education

MEDICAL REFERRAL FORM FOR CONCUSSED ATHLETE

(To be filled out by Athletic Health Care Trainer (AHCT) and/or Team Physician)

Name _____ Grade _____ Age _____ School _____

Date of Concussion _____ Sport _____ Level: ❑ Jr. Varsity ❑ Varsity

Concussion History:
Date(s) of Previous Known Concussion(s) to the AHCT and/or Team Physician _____

Mechanism of Injury for Current Concussion:

_____

_____

Treatment: (Check all that apply)

❑ Removed from Participation ❑ Parent Notified ❑ Referral to ER
❑ Graded Symptom Checklist ❑ Cognitive Assessment ❑ Postural Assessment

Athletic Health Care Trainer _____ Phone _____

Dear Physician:

Please review and complete this form and have the student athlete return the form to his/her school's AHCT.

The purpose of this form is to ensure that student athletes return to play when safe and appropriate as directed by the most recent medical evidence. Please contact me if you have any questions (phone number above).

For information on concussions in young athletes, please refer to:
Consensus Statement on Concussion in Sport. *Clin J Sport Med 2009; 19:185-200.*

Return to Activity Plan (RAP):

Step 1. Complete cognitive rest. This may include staying home from school or limiting school hours and study for several days which would be determined by a physician and AHCT, 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 high school AHCT and is subject to clearance by the treating physician. These steps cannot begin until cleared by the treating physician for further activity.

(Each STEP is separated by a minimum of at least 24 hours.)

Step 3. Light exercise. Walking or riding a stationary bike.

Step 4. Running in the gym or on the field.

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 and 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 Steps 3-7 above).

Physician's Name _____ Phone _____

Physician's Signature _____ Date _____

DISTRIBUTION: WHITE-Athletic Health Care Trainer (AHCT); CANARY-Parent/Legal Guardian

Rev. 5/13. RS 13-1287 (Rev. of RS 12-0539)