Texas Orthopaedic Associates
Physician / Physician Assistant Report to Athletic Trainer / Coach
Lower Extremity

Name _____ School _____ Exam Date ____/___/____

Sex ☐ M ☐ F Age _____ DOB ____/____/_____ Injury Date ____/___/____

Sport_____ Position _____

Complaint_____ ☐ New Injury ☐ Re-injury ☐ Follow-up

History _____

_____

Examination _____

_____

Diagnostic Studies _____

Diagnosis _____

☐ Surgery / Tests _____

Recommendations ☐ Rest ☐ Ice ☐ Heat ☐ Contrast ☐ Compression ☐ Recover Motion

☐ Modalities _____ ☐ Brace / Splint / Tape_____

☐ Rehabilitation _____

_____

Ambulatory Status ☐ FWB ☐ PWB ☐ NWB ☐ Crutches

Sport Participation

☐ Must Contact Primary Care Physician For Further Care / Release To Play
☐ May Not Participate
☐ Participate Without Restriction On ____/____/____
☐ Participate With Restriction On ____/____/____

Restrictions _____

_____

Other Recommendations _____

Physician ☐ Curtis Bush, M.D. Signature_____

☐ Melanie Cobb, PA-C

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