



# Sports Conditioning and Rehabilitation

## *Injury Consultation Consent Form*

TODAY'S DATE \_\_\_\_\_ INSURANCE and TYPE \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRED BY \_\_\_\_\_

HIGH SCHOOL/COLLEGE: \_\_\_\_\_ GRADE: \_\_\_\_\_

COACH: \_\_\_\_\_ SPORT(s): \_\_\_\_\_

CLUB COACH INFORMATION \_\_\_\_\_

I, \_\_\_\_\_ hereby request and consent to the consultation for the following physical concern (injury): \_\_\_\_\_; and hereby consent to the performance of specific testing and therapeutic procedures as deemed necessary and as performed by an athletic trainer and/or physical therapist at Sports Conditioning and Rehabilitation of California, Inc. and their associates for the aforementioned problem. I understand, and am informed that, while extremely rare, there are some risks associated with testing procedures and therapeutic intervention. I understand that the purpose of the testing and therapeutic procedures will be explained to me prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.

I hereby acknowledge that I am a willing participant in this consultation; and understand and agree to the information presented above.

\_\_\_\_\_  
Participant Signature DATE \_\_\_\_\_

\_\_\_\_\_  
Signature of parent/guardian if participant is under 18 years old DATE \_\_\_\_\_

# Injury Consultation

To be completed by SCAR staff

PT Eligible? (Please circle) YES NO

Today's Date: \_\_\_\_\_

DOI: \_\_\_\_\_

Body Area:    Head    Neck    U.E.    L.E.    Trunk

Body Part: \_\_\_\_\_

Side:    Left    Right    Bilateral    Midline

History: \_\_\_\_\_

\_\_\_\_\_

MOI: \_\_\_\_\_

Acute    Subacute    Reinjury    Chronic

Inspection:    Swelling    Redness    Bruising    Deformity

Other: \_\_\_\_\_

Palpation: \_\_\_\_\_

\_\_\_\_\_

AROM: \_\_\_\_\_

PROM: \_\_\_\_\_

RROM: \_\_\_\_\_

Special Tests: \_\_\_\_\_

\_\_\_\_\_

Injury Assessment (Type/Side/Severity): \_\_\_\_\_

Injury Management Plan: \_\_\_\_\_

Program Recommendation:    \_\_\_ Physical Therapy    \_\_\_ Treatment Program    \_\_\_ SCIP

AT/PT Initials: \_\_\_\_\_

Notes:

Rev. 07/15