



Office of Sports Medicine
A Division of Health & Wellness Services
Pre 'Date of Service' Referral Form

Health Care Provider:
Address:
Address: Phone:
(City, State)

Student-Athlete Name Team Date of Birth

I authorize the release of this information to the Kutztown University Sports Medicine personnel.

The above named individual is a student-athlete at Kutztown University of PA and has chosen or been referred to you for a consultation and/or definitive treatment. Please complete this form and return to our office in order to maintain the student-athlete's medical eligibility.

Date of Care:

Findings:

Test Result(s): (ie. X-ray, MRI, CT, etc)

Diagnosis:

Treatment Plan: Full Activity Unable to Return at this Time (re-examination required)
Restricted Activity as follows:

Follow-up Requested: Yes / No

Name of Physician:
(Please print name & Initial)

IN ORDER TO COMPLETE THE MEDICAL RECORDS AND ASSURE APPROPRIATE FOLLOW-UP, PLEASE RETURN WITH THE STUDENT. IF A MORE DETAILED REPORT IS NECESSARY, PLEASE RETURN THIS COPY TO:

KUTZTOWN UNIVERSITY
SPORTS MEDICINE OFFICE
KUTZTOWN, PA 19530
(610) 683-4085
Fax: (610) 683-4664

Eugene Fellin, D.O.
Director of Medical Services
Team Physician

Renard M. Sacco, MEd, ATC, ROT
Coordinator of Sports Medicine