Roxbury High School
Athletic Training

Telephone: (973) 584-1200 x1287 ***Joseph M. Koch LAT, CSCS, MSEd.*** **Fax: (973) 252-7101**

Physician Head Injury Referral Form

Dear Physician: Date: _____

_____ has possibly suffered a concussion on _____ while participating in _____ with Roxbury High School and has been referred to you for evaluation. The following information provides some background on how we treat head injuries at Roxbury High School including post-concussion assessment and cognitive testing (ImPACT), symptom monitoring and return to play guidelines.

At the direction of our team physician, Dr. Claudia Ginsberg (973) 538-2334, we follow the concussion guidelines in accordance with the provisions of N.J.S.A. 18A: 40-41.1 et. Sec.

Post-concussion assessment and cognitive testing (ImPACT):

1. We perform pre-season baseline and post-concussion cognitive testing on all collision and contact sport participants using ImPACT (Immediate Post concussion Assessment and Cognitive Testing) software program to assist with the management of head injuries. Please note that this program is used only as a tool to assist with return to play decisions. Additional information about the program can be found at www.impacttest.com

Symptom Monitoring Protocol:

1. The athlete must fill out a daily symptom check list
2. Any deficit noted at time of injury is tested to see if back to norm.(i.e. Balance testing is performed for the first 3-5 days post injury)
3. Post-concussive ImPACT tests are taken once the athlete is symptom free and continue until their scores are at or near baseline. It is recommended that an individual's scores be statistically at or near their baseline scores prior to beginning exertion.

Return to Play Protocol:

1. Athlete must present this form to the athletic trainer once completed **by a physician trained in the evaluation and management of sports related concussions.**
2. **Alternatively,** a doctor's note may be presented stating that once the athlete is symptom free at rest, they are allowed to begin a 6 step graduated return protocol which is supervised by a licensed athletic trainer, school or team physician or designated school nurse trained in the evaluation and management of concussions and other head injuries.

6 Step Return Protocol: There should be approximately 24 hours for each stage and the athlete should return to the previous stage that did not cause symptoms if symptoms recur.

1. Rest until asymptomatic (physical and mental) which includes the completion of a full day of normal cognitive activities
2. Light aerobic exercise (e.g. stationary bike-less then 70% MHR)
3. Sport specific exercise (no head impact activities)
4. Non-contact training drills (may initiate progressive resistance exercise)
5. Normal training activities (**after consultation between supervising health care professional and attending physician).** If symptoms re-emerge, the school/team physician in consultation with the athlete's physician shall determine the student's return to participation protocol
6. Return to competition (game play)

_____

Joseph M. Koch LAT, CSCS, MSEd., Licensed Athletic Trainer
License #: 25MT000059400

Please indicate your diagnosis and treatment plan on the back of this page.

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Athlete's name: _____

Physician: Must check appropriate box

☐ **Yes**, I do feel that I am adequately trained in the evaluation and management of concussions

☐ **No,** I do not feel that I am adequately trained in the evaluation and management of concussions

Physician's Diagnosis: _____

Return to Activity: (Please check one)

___ **Athlete is to rest until asymptomatic** then may begin graduated return to participation protocol stated on the front of this form under the supervision of licensed athletic trainer.

___ **Athlete is asymptomatic** at rest and may begin the graduated return to participation protocol stated on the front of this form.

___ Athlete is to see me again before returning to play.

___ Athlete **does not have a concussion** or other head injury and is asymptomatic at rest and may return to interscholastic activity.

***** Please note that after completing the 4th step of the RTP protocol, the athletic trainer must receive approval from attending physician prior to progressing to step 5 which is full participation in practice*****

Additional comments:

Physician's Name: **(please use stamp)**
Address and phone

Physician's signature _____ Date_____