Norfolk Department of Parks & Recreation
Therapeutic Recreation Center

Physician Referral and Information Form

Participant's Name: _____ DOB: _____
Participant's Desired Therapeutic Recreation Class(es): _____
_____

MEDICAL INFORMATION (TO BE COMPLETED BY A MEDICAL PROFESSIONAL):

Primary/Secondary Diagnosis (please check all that apply):

☐ ADD/ADHD	☐ Hearing Impairment	☐ Other: _____
☐ Arthritis	☐ Heart Condition	_____
☐ Autism	☐ Intellectual Disability	_____
☐ Cerebral Palsy	☐ Schizophrenia	_____
☐ Depression	☐ Seizure Disorder	_____
☐ Down Syndrome	☐ Visual Impairment	_____

In my professional opinion, this participant MAY participate in Therapeutic Recreation Programs conducted by the Norfolk Therapeutic Recreation Center (indicate limitations/restrictions below).

☐ Yes, *without* restrictions ☐ Yes, *with* restrictions (see below) ☐ No

ADDITIONAL EXAMINER NOTES/RESTRICTIONS:

_____
_____
_____

_____ _____ _____
Physician's Signature *Telephone Number* *Date*

Physician's Stamp here:

I have read and understand this form and agree to adhere to any and all of the specific precautions recommended by the physician. I further agree that should the physical conditions or medication of the aforementioned individual change in any way I will immediately notify the Therapeutic Recreation Center of the Norfolk Department of Parks & Recreation.

_____ *(Signature)* _____ *(Date)*