



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):

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Condition	_____
<input type="checkbox"/> Autism	<input type="checkbox"/> Intellectual Disability	_____
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Schizophrenia	_____
<input type="checkbox"/> Depression	<input type="checkbox"/> Seizure Disorder	_____
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> 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:

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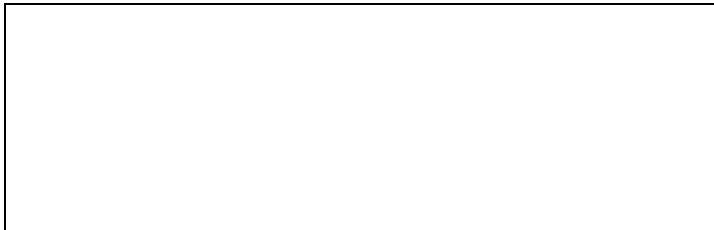
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Physician's Stamp here:



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)