Kerry Gustafson, AT/L, ATC, LMP
1433 N. State Street, Bellingham, WA 98225
Hours: Mon-Fri: 9am-6pm
Phone 360-319-3924
Fax 360-392-6245

Name_____

DOB _____ Diagnosis (ICD-10) _____

Comments/Precautions/Goals _____

(Circle any/all as appropriate)

Neck & Back Pain TMJ dysfunction Headache Upper Back Pain
Shoulder Rotator Cuff Impingement Post-Operative Orthopedic Rehabilitation
Sports and Dance Injury The First Year of Childbirth Motor Vehicle Injury
Foot/Ankle Injury Hip Injury Elbow Injury Sprain and Strain L&I

Treatment Services Offered (circle any/all as appropriate)

- Evaluate and treat per AT discretion
- Passive/Active ROM
- Therapeutic Exercise
- Stretching/Flexibility Techniques
- Proprioceptive Neuromuscular Facilitation (PNF)
- Myofascial Release
- Soft Tissue and Joint Mobilization
- Progressive Resistive Exercise
- Sports Injury Prevention Program
- Return to Sports Functional Training
- Balance/Proprioception
- Neuromuscular Re-education
- Dynamic Back/Neck Stabilization
- Home Exercise Program
- Posture Retraining
- Biomechanics of Bending and Lifting
- Orthopedic Sport Screen
- Massage Therapy
- Other_____

Frequency: 1x/wk 2x/wk 3x/wk Other **Duration**: 2 weeks 3 weeks 4 weeks Other

Health Care Provider - Signature (required) _____

Date _____

In making this referral, HCP certifies that athletic training services are a medical necessity.
Health Care Provider Name (print)_____

Office Telephone _____