

# INJURY REPORTING FORM

Event: \_\_\_\_\_

Full Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

Gender: M  F

Player / Referee / Coach / Spectator

Sport: \_\_\_\_\_ Team: \_\_\_\_\_

Grade: \_\_\_\_\_

Venue/area at which injury occurred: \_\_\_\_\_

<p><b>Date of injury</b> ___/___/___</p> <p><b>Time of arrival</b> _____</p> <p><b>Type of activity at time of injury</b></p> <p><input type="checkbox"/> training/practice</p> <p><input type="checkbox"/> competition</p> <p><input type="checkbox"/> other _____</p> <p><b>Reason for Presentation</b></p> <p><input type="checkbox"/> new injury</p> <p><input type="checkbox"/> exacerbated/aggravated injury</p> <p><input type="checkbox"/> recurrent injury</p> <p><input type="checkbox"/> illness</p> <p><input type="checkbox"/> other _____</p> <p><b>Body Region Injured</b></p> <p>Tick or circle body part/s injured &amp; name</p> <div style="text-align: center;"> </div> <p><b>Body part/s</b></p> <p>_____</p> <p>_____</p>	<p><b>Nature of Injury/Illness</b></p> <p><input type="checkbox"/> abrasion/graze</p> <p><input type="checkbox"/> sprain eg ligament tear</p> <p><input type="checkbox"/> strain eg muscle tear</p> <p><input type="checkbox"/> open wound/laceration/cut</p> <p><input type="checkbox"/> bruise/contusion</p> <p><input type="checkbox"/> inflammation/swelling</p> <p><input type="checkbox"/> fracture (including suspected)</p> <p><input type="checkbox"/> dislocation/subluxation</p> <p><input type="checkbox"/> overuse injury to muscle or tendon</p> <p><input type="checkbox"/> blisters</p> <p><input type="checkbox"/> concussion</p> <p><input type="checkbox"/> cardiac problem</p> <p><input type="checkbox"/> respiratory problem</p> <p><input type="checkbox"/> loss of consciousness</p> <p><input type="checkbox"/> unspecified medical condition</p> <p><input type="checkbox"/> other _____</p> <p><b>Provisional diagnosis/es</b> _____</p> <p>_____</p> <p style="text-align: center;"><b>CAUSE OF INJURY</b></p> <p><b>Mechanism of Injury</b></p> <p><input type="checkbox"/> struck by other player</p> <p><input type="checkbox"/> struck by ball or object</p> <p><input type="checkbox"/> collision with other player/referee</p> <p><input type="checkbox"/> collision with fixed object</p> <p><input type="checkbox"/> fall/stumble on same level</p> <p><input type="checkbox"/> jumping to shoot, defend/rebound</p> <p><input type="checkbox"/> fall from height/awkward landing</p> <p><input type="checkbox"/> gradual onset, no specific mechanism identified</p> <p><input type="checkbox"/> slip/trip</p> <p><input type="checkbox"/> temperature related eg heat stress</p> <p><input type="checkbox"/> other _____</p>	<p><b>Explain exactly how the incident occurred</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Were there any contributing factors to the incident, unsuitable footwear, playing surface, equipment, foul play?</p> <p>_____</p> <p>_____</p> <p><b>Protective Equipment</b></p> <p>Was protective equipment worn on the injured body part? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If yes, what type eg mouthguard, ankle brace, taping.</p> <p>_____</p> <p><b>Initial Treatment</b></p> <p><input type="checkbox"/> none given (not required)</p> <p><input type="checkbox"/> RICER</p> <p><input type="checkbox"/> dressing</p> <p><input type="checkbox"/> sling, splint</p> <p><input type="checkbox"/> massage</p> <p><input type="checkbox"/> manual therapy</p> <p><input type="checkbox"/> oxygen therapy</p> <p><input type="checkbox"/> CPR / defibrillater</p> <p><input type="checkbox"/> stretch/exercises</p> <p><input type="checkbox"/> strapping/taping</p> <p><input type="checkbox"/> none given - referred elsewhere</p> <p><input type="checkbox"/> other _____</p> <p><b>Consumables Used</b></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Advice Given</b></p> <p><input type="checkbox"/> immediate return unrestricted activity</p> <p><input type="checkbox"/> able to return with restriction</p> <p><input type="checkbox"/> unable to return at present time</p> <p><b>Referral</b></p> <p><input type="checkbox"/> no referral</p> <p><input type="checkbox"/> medical practitioner</p> <p><input type="checkbox"/> physiotherapist</p> <p><input type="checkbox"/> chiropractor or other professional</p> <p><input type="checkbox"/> ambulance transport</p> <p><input type="checkbox"/> hospital</p> <p><input type="checkbox"/> other _____</p> <p><b>Provisional severity assessment</b></p> <p><input type="checkbox"/> mild (<i>1-7 days modified activity</i>)</p> <p><input type="checkbox"/> moderate (<i>8-21 days modified activity</i>)</p> <p><input type="checkbox"/> severe (<i>&gt;21 days modified or lost</i>)</p> <p><b>Notes</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Treating person</b></p> <p><input type="checkbox"/> medical practitioner</p> <p><input type="checkbox"/> physiotherapist</p> <p><input type="checkbox"/> nurse / paramedic</p> <p><input type="checkbox"/> sports trainer – <input type="checkbox"/> level 1 <input type="checkbox"/> level 2</p> <p>_____</p> <p><b>Signature of treating person</b></p> <p>_____</p> <p><b>Printed name of treating person</b></p> <p>_____</p> <p><b>Today's date</b> ___/___/___</p> <p><b>Time discharged</b> _____</p>
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