INJURY REPORTING FORM

Event:_____

Full Name: _____ DOB: __/__/__ Gender: M ☐ F ☐ Player / Referee / Coach / Spectator

Sport:_____ **Team :** _____ Grade: _____ Venue/area at which injury occurred: _____

Date of injury ___/___/_____

Time of arrival _____

Type of activity at time of injury

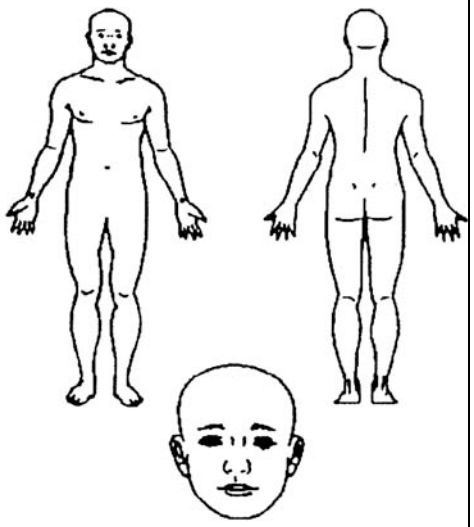
☐ training/practice
☐ competition
☐ other _____

Reason for Presentation

☐ new injury
☐ exacerbated/aggravated injury
☐ recurrent injury
☐ illness
☐ other _____

Body Region Injured

Tick or circle body part/s injured & name



Body part/s

_____

_____

Nature of Injury/Illness

☐ abrasion/graze
☐ sprain eg ligament tear
☐ strain eg muscle tear
☐ open wound/laceration/cut
☐ bruise/contusion
☐ inflammation/swelling
☐ fracture (including suspected)
☐ dislocation/subluxation
☐ overuse injury to muscle or tendon
☐ blisters
☐ concussion
☐ cardiac problem
☐ respiratory problem
☐ loss of consciousness
☐ unspecified medical condition
☐ other _____

Provisional diagnosis/es _____

_____

_____

CAUSE OF INJURY

Mechanism of Injury

☐ struck by other player
☐ struck by ball or object
☐ collision with other player/referee
☐ collision with fixed object
☐ fall/stumble on same level
☐ jumping to shoot, defend/rebound
☐ fall from height/awkward landing
☐ gradual onset, no specific mechanism identified
☐ slip/trip
☐ temperature related eg heat stress
☐ other _____

Explain exactly how the incident occurred

_____

_____

_____

_____

_____

_____

_____

Were there any contributing factors to the incident, unsuitable footwear, playing surface, equipment, foul play?

_____

_____

Protective Equipment

Was protective equipment worn on the injured body part? ☐ yes ☐ no

If yes, what type eg mouthguard, ankle brace, taping.

_____

Initial Treatment

☐ none given (not required)
☐ RICER
☐ dressing
☐ sling, splint
☐ massage
☐ manual therapy
☐ oxygen therapy
☐ CPR / defibrillater
☐ stretch/exercises
☐ strapping/taping
☐ none given - referred elsewhere
☐ other _____

Consumables Used

_____

_____

_____

Advice Given

☐ immediate return unrestricted activity
☐ able to return with restriction
☐ unable to return at present time

Referral

☐ no referral
☐ medical practitioner
☐ physiotherapist
☐ chiropractor or other professional
☐ ambulance transport
☐ hospital
☐ other _____

Provisional severity assessment

☐ mild *(1-7 days modified activity)*
☐ moderate *(8-21 days modified activity)*
☐ severe *(>21 days modified or lost)*

Notes

_____

_____

_____

Treating person

☐ medical practitioner
☐ physiotherapist
☐ nurse / paramedic
☐ sports trainer – ☐ level 1 ☐ level 2

_____

Signature of treating person

_____

Printed name of treating person

Today's date __/__/__

Time discharged_____