

# Sports Injury Reporting Form

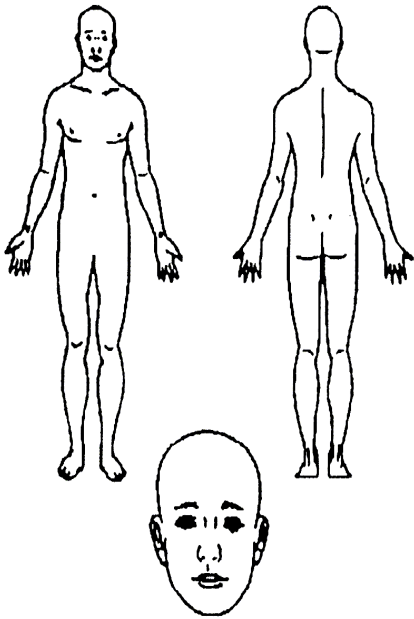


Name: \_\_\_\_\_ Address: \_\_\_\_\_

Sport: \_\_\_\_\_ Event: \_\_\_\_\_ Venue: \_\_\_\_\_ Team: \_\_\_\_\_

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time : \_\_\_\_ am/pm Gender:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Injured person (please circle): Player / Referee / Coach / Spectator

<p><b>TYPE OF ACTIVITY AT TIME OF INJURY</b></p> <p><input type="checkbox"/> training  <input type="checkbox"/> warm-up  <input type="checkbox"/> competition  <input type="checkbox"/> cool-down  <input type="checkbox"/> other _____</p> <p><b>REASON FOR PRESENTATION</b></p> <p><input type="checkbox"/> new injury  <input type="checkbox"/> aggravated injury  <input type="checkbox"/> recurrent injury  <input type="checkbox"/> illness  <input type="checkbox"/> other _____</p> <p><b>BODY PARTS INJURED</b>  <i>circle and name</i></p> <div style="text-align: center;">  </div> <p><b>NATURE OF INJURY/ILLNESS</b></p> <p><input type="checkbox"/> bruise/contusion  <input type="checkbox"/> cardiac problem  <input type="checkbox"/> cold/flu  <input type="checkbox"/> concussion  <input type="checkbox"/> dislocation/subluxation  <input type="checkbox"/> fracture (including suspected)  <input type="checkbox"/> inflammation/swelling  <input type="checkbox"/> loss of consciousness  <input type="checkbox"/> overuse injury  <input type="checkbox"/> respiratory problem  <input type="checkbox"/> skin injury e.g. graze/cut/blisters  <input type="checkbox"/> sprain e.g. ligament tear  <input type="checkbox"/> strain e.g. muscle tear  <input type="checkbox"/> unspecified medical condition  <input type="checkbox"/> other _____</p>	<p><b>CAUSE OF INJURY</b></p> <p><input type="checkbox"/> collision with fixed object  <input type="checkbox"/> collision with another player  <input type="checkbox"/> fall from height/awkward landing  <input type="checkbox"/> jumping to shoot or defend  <input type="checkbox"/> overexertion  <input type="checkbox"/> overuse  <input type="checkbox"/> slip/trip/fall/stumble  <input type="checkbox"/> struck by ball/object  <input type="checkbox"/> struck by another player  <input type="checkbox"/> temperature related  <input type="checkbox"/> other _____</p> <p><b>Explain how the incident occurred</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Were there any contributing factors to the incident? e.g. unsuitable footwear, playing surface, equipment, foul play</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Was protective equipment worn on the injured body part?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, what? e.g. mouth guard, brace?                  _____</p> <p>_____</p> <p><b>ACTION TAKEN</b></p> <p><input type="checkbox"/> none given (not required)  <input type="checkbox"/> CPR  <input type="checkbox"/> dressing  <input type="checkbox"/> immobilization  <input type="checkbox"/> RICER  <input type="checkbox"/> sling/splint  <input type="checkbox"/> strapping/taping  <input type="checkbox"/> stretch/exercises  <input type="checkbox"/> transport from field/court  <input type="checkbox"/> other _____</p>	<p><b>ADVICE GIVEN</b></p> <p><input type="checkbox"/> immediate return to activity  <input type="checkbox"/> return to play with restriction                  _____</p> <p><input type="checkbox"/> unable to return at present  <input type="checkbox"/> referred for further assessment before returning to activity</p> <p><b>NOTICE</b>                  The injured person told that if injury/illness does NOT improve in the following 24 hours they MUST seek further advice from their own medical professional.  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>REFERRAL</b></p> <p><input type="checkbox"/> no referral  <input type="checkbox"/> medical practitioner  <input type="checkbox"/> physiotherapist  <input type="checkbox"/> ambulance  <input type="checkbox"/> hospital  <input type="checkbox"/> other _____</p> <p><b>PROVISIONAL SEVERITY ASSESSMENT</b></p> <p><input type="checkbox"/> mild (1 - 7 days modified activity)  <input type="checkbox"/> moderate (8-21 days modified activity)  <input type="checkbox"/> severe (&gt;21 days modified or lost)</p> <p><b>TREATING PERSON</b></p> <p><input type="checkbox"/> Sports Trainer/Sports First Aider ( ID _____ )  <input type="checkbox"/> medical practitioner  <input type="checkbox"/> physiotherapist  <input type="checkbox"/> other _____</p> <p>Signature of injured person                  _____</p> <p>Signature of treating person                  _____</p> <p>Date: ____/____/____</p>
--	---	---