Injury Reporting Form

Name_____ Position_____ Circle Player/Referee/Coach/Volunteer/Spectator

Team_____ Grade_____ DOB_____/_____/_____ Gender ☐ Male ☐ Female Venue Area at which injury occurred_____

Date of Injury _____/_____/_____

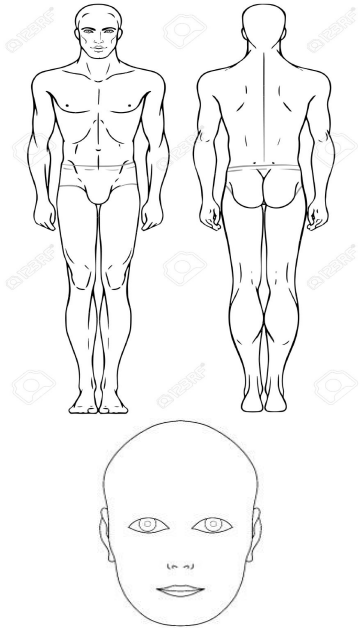
Type of activity at time of injury
☐ Training/Practice
☐ Competition

☐ 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
☐ Abrasions/Graze
☐ Sprain eg. Ligament tear
☐ Strain eg. Muscle tear
☐ Open wound/laceration/cut
☐ Bruise/contusion
☐ Inflammation/swelling
☐ Fracture (including suspected)
☐ Dislocation/subluxation
☐ Overuse injury due to muscle or tendon
☐ Blisters
☐ Concussion
☐ Cardiac Problem
☐ Respiratory problem
☐ Loss of consciousness
☐ Unspecified medical condition

☐ Other_____

Provisional diagnosis_____

_____

_____

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
☐ Heading ball
☐ Fall from height/awkward landing
☐ Overextension (eg. Muscle tear)
☐ Overuse
☐ 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 part? ☐ Yes ☐ No

If yes, what type eg. Mouthguard, ankle brace, taping, shin guard.

_____

Initial Treatment
☐ None given (not required)
☐ RICER ☐ Dressing
☐ Sling, splint ☐ Crutches
☐ Massage ☐ Manual Therapy
☐ CPR ☐ Stretch exercises
☐ Strapping/taping only
☐ None given – Referred elsewhere

☐ Other_____

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)

Treating Person
☐ Medical Practitioner
☐ Physiotherapist
☐ Nurse
☐ Sports Trainer

☐ Other_____

Signature of Treating Person

_____

Today's Date

_____/_____/_____