

Injury Report Form

Event: _____

Sport / Activity: _____

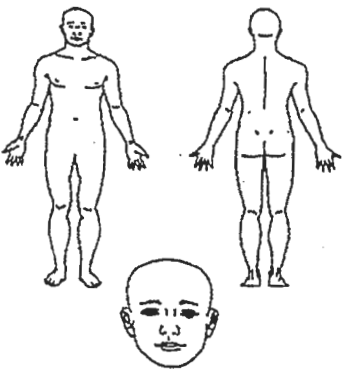
Venue: _____

Player / Referee / Coach / Spectator

Full Name: _____

DOB: ____/____/____ Gender: M F

Team / School: _____

<p>Date of injury ____/____/____</p> <p>Time of arrival _____</p> <p>Type of activity at time of injury</p> <p><input type="checkbox"/> training/practice</p> <p><input type="checkbox"/> competition</p> <p><input type="checkbox"/> other _____</p> <p>Reason for Presentation</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"/> other _____</p> <p>Body Region Injured</p> <div style="text-align: center;">  </div> <p>Region</p> <p>_____</p> <p>_____</p> <p>Nature of Injury/Illness</p> <p><input type="checkbox"/> illness</p> <p><input type="checkbox"/> bruise /contusion</p> <p><input type="checkbox"/> abrasion /graze</p> <p><input type="checkbox"/> open wound / laceration / cut</p> <p><input type="checkbox"/> sprain eg. ligament tear</p> <p><input type="checkbox"/> strain eg. muscle tear</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"/> head injury</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"/> other _____</p>	<p>Provisional diagnosis/es</p> <p>_____</p> <p>_____</p> <p>CAUSE OF INJURY</p> <p>Mechanism of Injury</p> <p><input type="checkbox"/> slip / trip / fall / stumble</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 from height /awkward landing</p> <p><input type="checkbox"/> temperature related eg. heat stress</p> <p><input type="checkbox"/> gradual onset, no specific mechanism identified</p> <p><input type="checkbox"/> other _____</p> <p>Explain exactly how the incident occurred</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>Protective Equipment</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>_____</p> <p>Initial Treatment</p> <p><input type="checkbox"/> RICER</p> <p><input type="checkbox"/> taping</p> <p><input type="checkbox"/> wound care</p> <p><input type="checkbox"/> sling / splint</p> <p><input type="checkbox"/> CPR / defibrillator / oxygen</p> <p><input type="checkbox"/> none given - not required</p> <p><input type="checkbox"/> none given - referred elsewhere</p> <p><input type="checkbox"/> other _____</p>	<p>Consumables used</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Advice Given</p> <p><input type="checkbox"/> immediate return unrestricted</p> <p><input type="checkbox"/> able to return with restriction</p> <p><input type="checkbox"/> unable to return at present time</p> <p>Referral</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 / hospital</p> <p><input type="checkbox"/> other _____</p> <p>Notes</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Treating person</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>Signature of treating person</p> <p>_____</p> <p>Printed name of treating person</p> <p>_____</p> <p>Time discharged _____</p>
---	---	--

Privacy Statement – Sports Medicine Australia (WA Branch) abides by the relevant National Privacy Principles of the *Privacy Act 1988*. The information on this form is to be retained by SMA (WA Branch). The information is used for but not limited to providing medical assistance, injury surveillance information and possibly legal and insurance purposes. You can get more information about the way SMA (WA Branch) manages your personal information by contacting the office on (08) 9285 8033. Please note you may gain access to your personal information in accordance with the *Privacy Act 1988*.

Disclaimer – "The information contained in this resource is in the nature of general comment only, and neither purports, nor is intended, to be advice on particular matter. No reader should act on the basis of anything contained in this resource without seeking independent professional advice from appropriate persons. No responsibility or liability whatsoever can be accepted by Sports Medicine Australia (WA Branch) or the authors for any loss, damage or injury that may arise from any person acting on any statement of information contained in this resource and all such liabilities are expressly disclaimed.