

INJURY REPORT FORM

Name: _____

Address: _____

Phone: _____ DOB: ____ / ____ / ____

☐ Male ☐ Female English speaking: ☐ Y ☐ N

Venue: _____

Report Time: _____ Date: ____ / ____ / ____

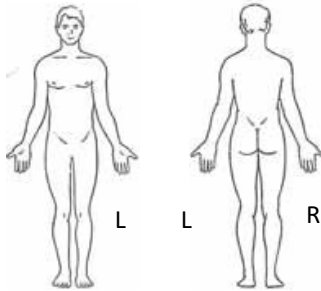
Team _____

☐ Player ☐ Official ☐ Spectator ☐ Other

Activity at time of injury:

☐ Training / Practice ☐ Competition ☐ Other

BODY PART/S INJURED:



REASON FOR PRESENTATION: ☐ New Injury ☐ Aggravated Injury

☐ Recurrent Injury ☐ Other _____

Talk Observe Touch Active Passive Skill (TOTAPS) / History:

R

CAUSE OF INJURY:	INITIAL MANAGEMENT:	ADVICE GIVEN (after TOTAPS):
<input type="radio"/> Struck by other player	<input type="radio"/> None given	<input type="radio"/> Immediate return to activity
<input type="radio"/> Struck by Ball / object	<input type="radio"/> Referred	<input type="radio"/> Return with restriction
<input type="radio"/> Collision with other player	<input type="radio"/> RICER & Warnings	
<input type="radio"/> Collision with fixed object	<input type="radio"/> Wound	
<input type="radio"/> Overexertion	<input type="radio"/> Asthma	<input type="radio"/> Unable to return at present
<input type="radio"/> Overuse	<input type="radio"/> Strapping / Taping	<input type="radio"/> Unable to return until medical clearance given
<input type="radio"/> Landing	<input type="radio"/> Rest / Monitor	
<input type="radio"/> Slip / Trip / Fall / Stumble	<input type="radio"/> Sling / Splint	REFERRAL: at initial assessment
<input type="radio"/> Temperature related <input type="radio"/>	<input type="radio"/> Immobilise	<input type="radio"/> Own Medical Practitioner
Other _____	<input type="radio"/> CPR	<input type="radio"/> Medical Practitioner
	<input type="radio"/> Other _____	<input type="radio"/> Own Physiotherapist
SUSPECTED NATURE OF INJURY ILLNESS:		<input type="radio"/> Physiotherapist
<input type="radio"/> Soft Tissue		<input type="radio"/> Sports Injury Clinic
<input type="radio"/> Hard Tissue <input type="radio"/> Dislocation	<input type="radio"/> ICE : 15-20 min every 2 hours next 2 to 3 Days	<input type="radio"/> Ambulance
<input type="radio"/> Dehydration		<input type="radio"/> Hospital
<input type="radio"/> Hyperthermia / Hypothermia		<input type="radio"/> Other _____
<input type="radio"/> Wound /Open/ Graze/Abrasion	INJURED PLAYER REPORT:	TREATING PERSONS:
<input type="radio"/> Blister	Injured player told that if injury / illness does NOT improve in the next 24 hours they MUST seek further advice from their own medical professional.	<input type="radio"/> Level 1 Accredited Sports Trainer
<input type="radio"/> Vomiting		<input type="radio"/> Level 2 Accredited Sports Trainer
<input type="radio"/> Respiratory	<input type="radio"/> Yes	<input type="radio"/> Registered Nurse
<input type="radio"/> Concussion		<input type="radio"/> Doctor
<input type="radio"/> Loss of consciousness		<input type="radio"/> Physiotherapist
<input type="radio"/> Other _____		Signature _____
		Name _____

"I declare that to the best of my knowledge the above information is correct"

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