INJURY REPORT FORM

Name: _____

Address: _____

_____

Phone: _____ **DOB:** ___ /___ /_____

❑ Male ❑ Female **English speaking:** ❑ Y ❑ N

Sport: _____ **Venue:** _____

Report Time: _____ **Date:** ___ / ___ / _____

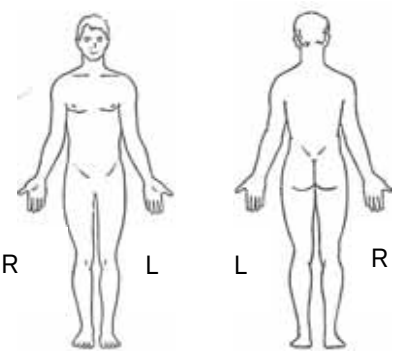
Team / School: _____

❑ Player ❑ Official ❑ Spectator ❑ Other

Activity at time of injury:

❑ Training / Practice ❑ Competition ❑ Other

BODY PART / S INJURED:



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_____

REASON FOR PRESENTATION: ❑ New Injury ❑ Aggravated Injury ❑ Recurrent Injury ❑ Other _____

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

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_____

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CAUSE OF INJURY:

- ❑ Struck by other player
- ❑ Struck by Ball / object
- ❑ Collision with other player
- ❑ Collision with fixed object
- ❑ Overexertion
- ❑ Overuse
- ❑ Landing
- ❑ Slip / Trip / Fall / Stumble
- ❑ Temperature related
- ❑ Other _____

SUSPECTED NATURE OF INJURY ILLNESS:

- ❑ Soft Tissue
- ❑ Hard Tissue
- ❑ Dislocation
- ❑ Dehydration
- ❑ Hyperthermia / Hypothermia
- ❑ Wound /Open/ Graze/Abrasion
- ❑ Blister
- ❑ Vomiting
- ❑ Respiratory
- ❑ Concussion
- ❑ Loss of consciousness
- ❑ Other

_____

INITIAL MANAGEMENT:

- ❑ None given
- ❑ Referred
- ❑ RICER & Warnings
- ❑ Wound
- ❑ Asthma
- ❑ Strapping / Taping
- ❑ Rest / Monitor
- ❑ Sling / Splint
- ❑ Immobilise
- ❑ CPR
- ❑ Other_____

_____

❑ **ICE : 15-20 min every 2 hours next 2 to 3 Days**

INJURED PLAYER REPORT:
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.

❑ Yes

ADVICE GIVEN (after TOTAPS):

- ❑ Immediate return to activity
- ❑ Return with restriction

_____

_____

- ❑ Unable to return at present
- ❑ Unable to return until medical clearance given

REFERRAL: at initial assessment

- ❑ Own Medical Practitioner
- ❑ Medical Practitioner
- ❑ Own Physiotherapist
- ❑ Physiotherapist
- ❑ Sports Injury Clinic
- ❑ Ambulance
- ❑ Hospital
- ❑ Other _____

TREATING PERSONS:

- ❑ Level 1 Accredited Sports Trainer
- ❑ Level 2 Accredited Sports Trainer
- ❑ Registered Nurse
- ❑ Doctor
- ❑ Physiotherapist

Signature _____

Name _____

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