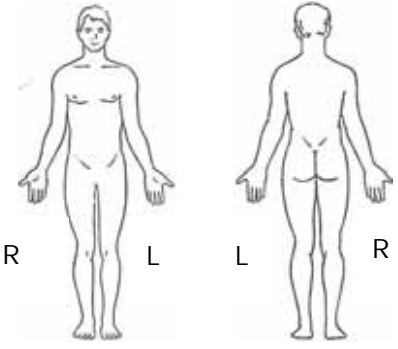


# INJURY REPORT FORM

**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:**



\_\_\_\_\_

\_\_\_\_\_

**REASON FOR PRESENTATION:**  New Injury  Aggravated Injury  
 Recurrent Injury  Other \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 \_\_\_\_\_

**INITIAL MANAGEMENT:**

None given  
 Referred  
 RICER & Warnings  
 Wound  
 Asthma  
 Strapping / Taping  
 Rest / Monitor  
 Sling / Splint  
 Immobilise  
 CPR  
 Other \_\_\_\_\_

**ADVICE GIVEN (after TOTAPS):**

Immediate return to activity  
 Return with restriction \_\_\_\_\_

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

**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 \_\_\_\_\_

**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

**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"*

**PRIVACY STATEMENT** – Our organization abides by the relevant National Privacy Principles of the *Privacy Act 1988*. The information on this form is to be retained by the organization that has arranged this sporting event / activity. 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 our organization manages your personal information by contacting club officials. Please note you may gain access to your personal information in accordance with the *Privacy Act 1988* and have it corrected, if required.  
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