



Name of patient: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_:\_\_\_\_am/pm  
 Sex: Male  Female  Sport \_\_\_\_\_ The injured person is: Player\_Referee\_Coach\_Spectator  
 Patient Address: \_\_\_\_\_ Postcode \_\_\_\_\_ Phone: \_\_\_\_\_

Venue \_\_\_\_\_ Event/match \_\_\_\_\_

<p><b>Type of activity at time of injury</b></p> <p><input type="checkbox"/> training  <input type="checkbox"/> warm-up  <input type="checkbox"/> competition  <input type="checkbox"/> cool-down  <input type="checkbox"/> other _____</p> <p><b>Reason for Presentation</b></p> <p><input type="checkbox"/> new injury  <input type="checkbox"/> exacerbated/aggravated injury  <input type="checkbox"/> recurrent injury  <input type="checkbox"/> illness  <input type="checkbox"/> other _____</p> <p><b>Body Region Injured</b>        Tick or circle body part/s injured &amp; name</p> <div style="text-align: center;"> </div> <p><b>Body part/s</b></p> <p>_____</p> <p>_____</p>	<p><b>Nature of Injury/Illness</b></p> <p><input type="checkbox"/> abrasion/graze  <input type="checkbox"/> sprain eg ligament tear  <input type="checkbox"/> strain eg muscle tear  <input type="checkbox"/> open wound/laceration/cut  <input type="checkbox"/> bruise/contusion  <input type="checkbox"/> inflammation/swelling  <input type="checkbox"/> fracture (including suspected)  <input type="checkbox"/> dislocation/subluxation  <input type="checkbox"/> overuse injury to muscle or tendon  <input type="checkbox"/> blisters  <input type="checkbox"/> concussion  <input type="checkbox"/> cardiac problem  <input type="checkbox"/> respiratory problem  <input type="checkbox"/> loss of consciousness  <input type="checkbox"/> unspecified medical condition  <input type="checkbox"/> other _____</p> <p><b>Provisional diagnosis/es</b></p> <hr/> <p><b>Mechanism of Injury</b></p> <p><input type="checkbox"/> struck by other player  <input type="checkbox"/> struck by ball or object  <input type="checkbox"/> collision with other player/referee  <input type="checkbox"/> collision with fixed object  <input type="checkbox"/> fall/stumble on same level  <input type="checkbox"/> jumping to shoot or defend  <input type="checkbox"/> fall from height/awkward landing  <input type="checkbox"/> overexertion (eg muscle tear)  <input type="checkbox"/> overuse  <input type="checkbox"/> slip/trip  <input type="checkbox"/> temperature related eg heat stress  <input type="checkbox"/> other _____</p>	<p>Explain exactly how the incident occurred: _____</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><b>Protective Equipment</b>        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, _____</p> <p><b>Initial Treatment</b></p> <p><input type="checkbox"/> none given (not required)  <input type="checkbox"/> RICER <input type="checkbox"/> dressing  <input type="checkbox"/> sling, splint <input type="checkbox"/> crutches  <input type="checkbox"/> CPR <input type="checkbox"/> stretch/exercises  <input type="checkbox"/> taping only  <input type="checkbox"/> none given - referred elsewhere  <input type="checkbox"/> other _____</p> <p><b>Advice Given</b></p> <p><input type="checkbox"/> Immediate return, unrestricted activity  <input type="checkbox"/> Able to return with restriction  <input type="checkbox"/> Unable to return at the present time  <input type="checkbox"/> Able to return but the player chose not to  <input type="checkbox"/> Referred for further assessment before returning to activity</p>
<p><b>Type of activity at time of injury</b></p> <p><input type="checkbox"/> training  <input type="checkbox"/> warm-up  <input type="checkbox"/> competition  <input type="checkbox"/> cool-down  <input type="checkbox"/> other _____</p> <p><b>Reason for Presentation</b></p> <p><input type="checkbox"/> new injury  <input type="checkbox"/> exacerbated/aggravated injury  <input type="checkbox"/> recurrent injury  <input type="checkbox"/> illness  <input type="checkbox"/> other _____</p> <p><b>Body Region Injured</b>        Tick or circle body part/s injured &amp; name</p> <div style="text-align: center;"> </div> <p><b>Body part/s</b></p> <p>_____</p> <p>_____</p>	<p><b>Referral</b></p> <p><input type="checkbox"/> no referral  <input type="checkbox"/> medical practitioner  <input type="checkbox"/> physiotherapist  <input type="checkbox"/> ambulance transport  <input type="checkbox"/> hospital  <input type="checkbox"/> other _____</p> <p><b>Provisional severity assessment</b></p> <p><input type="checkbox"/> mild (1-7 days modified activity)  <input type="checkbox"/> moderate (8-21 days modified activity)  <input type="checkbox"/> severe (&gt;21 days modified or lost)</p> <p><b>Treating person</b></p> <p><input type="checkbox"/> medical practitioner  <input type="checkbox"/> sports trainer ( ID _____ )  <input type="checkbox"/> other _____</p> <p><b>Treating Persons Name</b></p> <p>_____</p> <p><b>Signature</b></p> <p>_____</p>	<p><b>Referral</b></p> <p><input type="checkbox"/> no referral  <input type="checkbox"/> medical practitioner  <input type="checkbox"/> physiotherapist  <input type="checkbox"/> ambulance transport  <input type="checkbox"/> hospital  <input type="checkbox"/> other _____</p> <p><b>Provisional severity assessment</b></p> <p><input type="checkbox"/> mild (1-7 days modified activity)  <input type="checkbox"/> moderate (8-21 days modified activity)  <input type="checkbox"/> severe (&gt;21 days modified or lost)</p> <p><b>Treating person</b></p> <p><input type="checkbox"/> medical practitioner  <input type="checkbox"/> sports trainer ( ID _____ )  <input type="checkbox"/> other _____</p> <p><b>Treating Persons Name</b></p> <p>_____</p> <p><b>Signature</b></p> <p>_____</p>