

# INJURY REPORT FORM

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone \_\_\_\_\_ Sport: \_\_\_\_\_ Venue: \_\_\_\_\_ Team: \_\_\_\_\_  
 Report Time: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: M F DoB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<p><b>REASON FOR PRESENTATION</b></p> <p><input type="checkbox"/> New injury</p> <p><input type="checkbox"/> Aggravated injury</p> <p><input type="checkbox"/> Recurrent injury</p> <p><input type="checkbox"/> Illness</p> <p><input type="checkbox"/> Other- _____</p> <hr/> <p style="text-align: center;"><b>DRSABCD</b></p> <p><input type="checkbox"/> Yes</p> <hr/> <p><b>BODY PART/S INJURED</b></p> <p>_____</p>	<p style="text-align: center;"><b>TOTAPS / HISTORY</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p><b>CAUSE OF INJURY</b></p> <p><input type="checkbox"/> Struck by other player</p> <p><input type="checkbox"/> Struck by ball/object</p> <p><input type="checkbox"/> Collision with other player</p> <p><input type="checkbox"/> Collision with fixed object</p> <p><input type="checkbox"/> Overexertion</p> <p><input type="checkbox"/> Overuse</p> <p><input type="checkbox"/> Landing</p> <p><input type="checkbox"/> Slip/Trip/Fall/Stumble</p> <p><input type="checkbox"/> Temperature related</p> <p><input type="checkbox"/> Other</p> <hr/> <p><b>SUSPECTED NATURE OF INJURY/ILLNESS</b></p> <p><input type="checkbox"/> Soft Tissue</p> <p><input type="checkbox"/> Hard Tissue</p> <p><input type="checkbox"/> Wound/open/graze/abrasion</p> <p><input type="checkbox"/> Inflammation</p> <p><input type="checkbox"/> Dislocation</p> <p><input type="checkbox"/> Blister</p> <p><input type="checkbox"/> Concussion</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Respiratory</p> <p><input type="checkbox"/> Loss of consciousness</p> <p><input type="checkbox"/> Unspecified medical</p> <p><input type="checkbox"/> Cold/Flu</p> <p><input type="checkbox"/> Illness</p> <p><input type="checkbox"/> Other</p> <p>_____</p>	<p><b>INITIAL MANAGEMENT</b></p> <p><input type="checkbox"/> None given</p> <p><input type="checkbox"/> Referred</p> <p><input type="checkbox"/> RICER + Warnings</p> <p><input type="checkbox"/> Sling/splint</p> <p><input type="checkbox"/> Immobilise</p> <p><input type="checkbox"/> Hypothermia / hyperthermia</p> <p><input type="checkbox"/> Wound</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Strapping/taping</p> <p><input type="checkbox"/> Massage</p> <p><input type="checkbox"/> CPR</p> <p><input type="checkbox"/> Infection disease control</p> <p><input type="checkbox"/> Rest/ Monitor</p> <p><input type="checkbox"/> Other</p> <p>_____</p> <p>_____</p> <p>_____</p> <hr/> <p><b>REFERRAL (if referred at initial assessment)</b></p> <p><input type="checkbox"/> Medical practitioner</p> <p><input type="checkbox"/> Ambulance</p> <p><input type="checkbox"/> Hospital</p> <p><input type="checkbox"/> Other</p> <p>Place/name of referral</p> <p>_____</p>	<p><b>ADVICE GIVEN (After TOTAPS)</b></p> <p><input type="checkbox"/> Immediate return to activity</p> <p><input type="checkbox"/> Return with restriction</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Unable to return at present</p> <p><input type="checkbox"/> Unable to return until clearance given</p> <hr/> <p><b>INJURED PLAYER REPORT</b></p> <p>Injured player told that if injury / illness does <b>NOT</b> improve in the following 24 hours they <b>MUST</b> seek further advice from their own medical professional</p> <p><input type="checkbox"/> Yes</p> <hr/> <p><b>TREATING PERSON'S ACCREDITATIONS</b></p> <p><input type="checkbox"/> Level 1 trainer</p> <p><input type="checkbox"/> Level 2 trainer</p> <p><input type="checkbox"/> Registered Nurse</p> <p><input type="checkbox"/> Doctor</p> <p><input type="checkbox"/> Physiotherapist</p> <p>Full name</p> <p>_____</p>

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

Signature of injured person/caregiver \_\_\_\_\_ Signature of treating person \_\_\_\_\_

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