# INJURY REPORTING FORM

Name: _____   Initials: _____   Position: _____   **Circle**   Player/Umpire/Coach/Spectator

Team: _____   Grade: _____   DOB: __/__/__   Gender: M ☐ F ☐   Venue/area at which injury occurred: _____

Date of Injury   __/__/__

Type of activity at time of injury
☐ Training/practice
☐ Competition
☐ Other _____

Reason for Presentation
☐ New injury
☐ Exacerbated/aggravated injury
☐ Recurrent injury
☐ Illness
☐ Other _____

Body Region Injured
Tick or circle body part/s injured & name
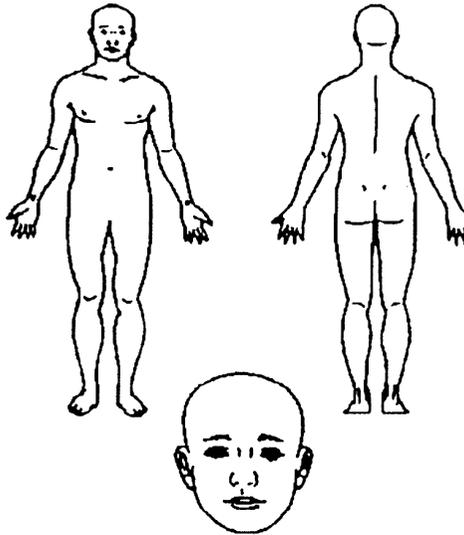
Body part/s
_____

_____

Nature of Injury/Illness
☐ Abrasion/graze
☐ Sprain eg ligament tear
☐ Strain eg muscle tear
☐ Open wound/laceration/cut
☐ Bruise/contusion
☐ Inflammation/swelling
☐ Fracture (including suspected)
☐ Dislocation/subluxation
☐ Overuse injury to muscle or tendon
☐ Blisters
☐ Concussion
☐ Cardiac problem
☐ Respiratory problem
☐ Loss of consciousness
☐ Unspecified medical condition
☐ Other _____

Provisional diagnosis/es _____
_____
_____

CAUSE OF INJURY

Mechanism of Injury
☐ Struck by other player
☐ Struck by ball or object
☐ Collision with other player/referee
☐ Collision with fixed object
☐ Fall/stumble on same level
☐ Jumping to shoot, defend/rebound
☐ Fall from height/awkward landing
☐ Gradual onset, no specific mechanism identified
☐ Slip/trip
☐ Temperature related eg heat stress
☐ Other _____

Explain exactly how the incident occurred
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Were there any contributing factors to the incident, unsuitable footwear, playing surface, equipment, and foul play?
_____
_____
_____

Protective Equipment
Was protective equipment worn on the injured body part? ☐ Yes ☐ no

If yes, what type eg mouthguard, ankle brace, taping?
_____

Initial Treatment
☐ None given (not required)
☐ RICER
☐ Dressing
☐ Sling, splint
☐ Crutches
☐ Massage
☐ Manual therapy
☐ CPR
☐ Stretch/exercises
☐ Strapping/taping only
☐ None given - referred elsewhere
☐ Other _____

Advice Given
☐ Immediate return unrestricted activity
☐ Able to return with restriction
☐ Unable to return at present time

Referral
☐ No referral
☐ Medical practitioner
☐ Physiotherapist
☐ Chiropractor or other professional
☐ Ambulance transport
☐ Hospital
☐ Other _____

Provisional severity assessment
☐ Mild (1-7 days modified activity)
☐ Moderate (8-21 days modified activity)
☐ Severe (>21 days modified or lost)

Treating person
☐ Medical practitioner
☐ Physiotherapist
☐ Nurse
☐ Sports trainer
☐ Other
_____

Signature of treating person
_____
_____

Today's Date: __/__/__