

# INJURY REPORT FORM - GENERAL



Name of patient: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_ Date of Injury: \_\_/\_\_/\_\_ Time: \_\_\_\_\_:\_\_\_\_\_am/pm  
 Sex: Male  Female  Sport: \_\_\_\_\_ The injured person is a: Player / Referee / Coach / Spectator Patient Address: \_\_\_\_\_  
 \_\_\_\_\_ Postcode: \_\_\_\_\_ Phone: \_\_\_\_\_

Venue: \_\_\_\_\_

Event/match: \_\_\_\_\_

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| <p><b>Type of activity at time of injury</b></p> <p><input type="checkbox"/> training<br/> <input type="checkbox"/> warm-up<br/> <input type="checkbox"/> competition<br/> <input type="checkbox"/> cool-down<br/> <input type="checkbox"/> other _____</p> <p><b>Reason for Presentation</b></p> <p><input type="checkbox"/> new injury<br/> <input type="checkbox"/> exacerbated/aggravated injury<br/> <input type="checkbox"/> recurrent injury<br/> <input type="checkbox"/> illness<br/> <input type="checkbox"/> other _____</p> <p><b>Body Region Injured</b><br/>                 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<br/> <input type="checkbox"/> sprain e.g. ligament tear<br/> <input type="checkbox"/> strain e.g. muscle tear<br/> <input type="checkbox"/> open wound/laceration/cut<br/> <input type="checkbox"/> bruise/contusion<br/> <input type="checkbox"/> inflammation/swelling<br/> <input type="checkbox"/> fracture (including suspected)<br/> <input type="checkbox"/> dislocation/subluxation<br/> <input type="checkbox"/> overuse injury to muscle or tendon<br/> <input type="checkbox"/> blisters<br/> <input type="checkbox"/> concussion<br/> <input type="checkbox"/> cardiac problem<br/> <input type="checkbox"/> respiratory problem<br/> <input type="checkbox"/> loss of consciousness<br/> <input type="checkbox"/> unspecified medical condition<br/> <input type="checkbox"/> other _____</p> <p><b>Provisional diagnosis/es</b></p> <p>_____</p> <p><b>Mechanism of Injury</b></p> <p><input type="checkbox"/> struck by other player<br/> <input type="checkbox"/> struck by ball or object<br/> <input type="checkbox"/> collision with other player/referee<br/> <input type="checkbox"/> collision with fixed object<br/> <input type="checkbox"/> fall/stumble on same level<br/> <input type="checkbox"/> jumping to shoot or defend<br/> <input type="checkbox"/> fall from height/awkward landing<br/> <input type="checkbox"/> overexertion (e.g. muscle tear)<br/> <input type="checkbox"/> overuse<br/> <input type="checkbox"/> slip/trip<br/> <input type="checkbox"/> temperature related e.g. heat stress<br/> <input type="checkbox"/> other _____</p> | <p>Explain exactly how the incident occurred:</p> <p>_____</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>_____</p> <p><b>Protective Equipment</b><br/>                 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)<br/> <input type="checkbox"/> RICER <input type="checkbox"/> dressing<br/> <input type="checkbox"/> sling, splint <input type="checkbox"/> crutches<br/> <input type="checkbox"/> CPR <input type="checkbox"/> stretch/exercises <input type="checkbox"/> taping only<br/> <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<br/> <input type="checkbox"/> Able to return with restriction<br/> <input type="checkbox"/> Unable to return at the present time <input type="checkbox"/> Able to return but the player chose not to<br/> <input type="checkbox"/> Referred for further assessment before returning to activity</p> | <p><b>Referral</b></p> <p><input type="checkbox"/> no referral<br/> <input type="checkbox"/> medical practitioner<br/> <input type="checkbox"/> physiotherapist<br/> <input type="checkbox"/> ambulance transport<br/> <input type="checkbox"/> hospital<br/> <input type="checkbox"/> other _____</p> <p><b>Provisional severity assessment</b></p> <p><input type="checkbox"/> mild (1-7 days modified activity)<br/> <input type="checkbox"/> moderate (8-21 days modified activity)<br/> <input type="checkbox"/> severe (&gt;21 days modified or lost)</p> <p><b>Treating person</b></p> <p><input type="checkbox"/> medical practitioner<br/> <input type="checkbox"/> sports trainer ( ID _____ )<br/> <input type="checkbox"/> other _____</p> <p><b>Treating Persons Name</b></p> <p>_____</p> <p><b>Signature</b> _____</p> <p><b>Completed form must be emailed</b></p> <p><b>to <a href="mailto:legana.tennis@gmail.com">legana.tennis@gmail.com</a> on</b></p> <p><b>the day of the incident.</b></p> |
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