



INJURY REPORTING FORM

Name: _____

Position: _____

Circle: Player / Referee / Coach / Spectator / Off Ice Official

Team : _____

Grade: _____ DOB: __/__/__

Gender: M F

Venue injury occurred: _____

Date of Injury __/__/__

Type of activity at time of injury

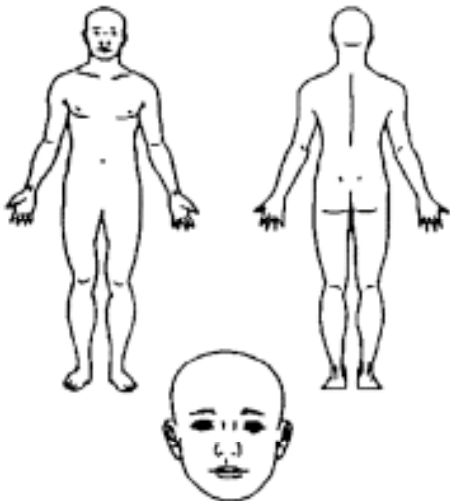
- training/practice
 - competition
 - other
- _____

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 puck or stick
 - collision with other player/referee
 - collision with fixed object
 - fall/stumble on same level
 - slip/trip
 - overexertion (eg muscle tear)
 - overuse
 - 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, foul play?

Protective Equipment

Was protective equipment worn on the injured body part? yes no

If yes, what type eg mouthguard, ankle brace, taping, shin pad.

Initial Treatment

- none (not required) _ ice
 - 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
- Delayed return with no 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
 - team medic
 - physiotherapist
 - nurse
 - sports trainer
 - other
- _____

Name of Treating Person:

Phone

Number: _____

Signature : _____

Today's Date: __/__/__