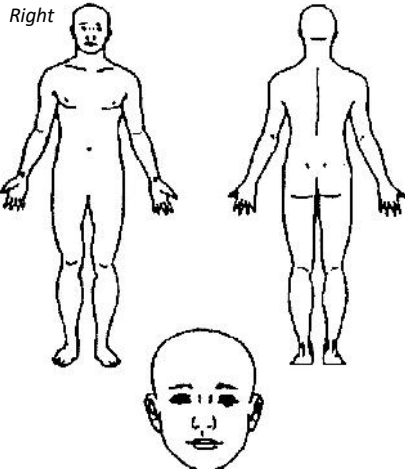


INJURY REPORT FORM

<p>Patients Name:</p> <p>.....</p> <p>Type of activity at time of injury</p> <p><input type="checkbox"/> practice</p> <p><input type="checkbox"/> competition</p> <p><input type="checkbox"/> recreational</p> <p><input type="checkbox"/> other</p> <p>Reason for Presentation</p> <p><input type="checkbox"/> new injury</p> <p><input type="checkbox"/> exacerbated/aggravated injury</p> <p><input type="checkbox"/> recurrent injury</p> <p><input type="checkbox"/> illness</p> <p><input type="checkbox"/> other</p> <p>Body Region Injured</p> <p>Tick or circle body part/s injured & name</p> <div style="text-align: center;"> <p>Right</p>  </div> <p>Body part/s</p> <p>.....</p> <p>.....</p>	<p>Nature of Injury/Illness</p> <p><input type="checkbox"/> abrasion/graze</p> <p><input type="checkbox"/> sprain e.g. ligament tear</p> <p><input type="checkbox"/> strain e.g. muscle tear</p> <p><input type="checkbox"/> open wound/laceration/cut</p> <p><input type="checkbox"/> bruise/contusion</p> <p><input type="checkbox"/> inflammation/swelling</p> <p><input type="checkbox"/> dislocation/subluxation</p> <p><input type="checkbox"/> overuse injury to muscle or tendon</p> <p><input type="checkbox"/> blisters</p> <p><input checked="" type="checkbox"/> fracture (including suspected) *</p> <p><input checked="" type="checkbox"/> concussion *</p> <p><input checked="" type="checkbox"/> cardiac problem *</p> <p><input checked="" type="checkbox"/> respiratory problem *</p> <p><input checked="" type="checkbox"/> loss of consciousness *</p> <p><input type="checkbox"/> unspecified medical condition</p> <p><input type="checkbox"/> other</p> <p>* Automatic Licence Suspension</p> <p>Provisional diagnosis/es</p> <hr/> <p>Mechanism of Injury</p> <p><input type="checkbox"/> High side</p> <p><input type="checkbox"/> Low side</p> <p><input type="checkbox"/> Impact</p> <p><input type="checkbox"/> Hit Wall / Barrier / Object</p> <p><input type="checkbox"/> Overexertion (eg muscle tear)</p> <p><input type="checkbox"/> Overuse</p> <p><input type="checkbox"/> Slip / Trip</p> <p><input type="checkbox"/> Temperature related eg. Heat stress</p> <p>Other</p> <p><input type="checkbox"/> Jump</p> <p><input type="checkbox"/> High Speed</p> <p><input type="checkbox"/> Medium Speed</p> <p><input type="checkbox"/> Low Speed</p> <p>Other</p>	<p>Protective Equipment</p> <p>Was protective equipment worn on the injured body part? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If yes, what type eg helmet, neck brace</p> <p>Initial Treatment</p> <p><input type="checkbox"/> none given (not required)</p> <p><input type="checkbox"/> RICER <input type="checkbox"/> dressing</p> <p><input type="checkbox"/> taping only <input type="checkbox"/> crutches</p> <p><input type="checkbox"/> sling, splint <input type="checkbox"/> stretch/exercises</p> <p><input type="checkbox"/> CPR</p> <p><input type="checkbox"/> none given - referred elsewhere</p> <p>other</p> <p>Advice Given</p> <p><input type="checkbox"/> Immediate return, unrestricted activity</p> <p><input type="checkbox"/> Able to return with restriction</p> <p><input type="checkbox"/> Unable to return at the present time</p> <p><input type="checkbox"/> Rider able to return but chose not to</p> <p><input type="checkbox"/> Referred for further assessment before returning to activity</p> <hr/> <p>Critical Incident?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, who is involved</p> <p><input type="checkbox"/> Police</p> <p><input type="checkbox"/> Coroner</p> <p><input type="checkbox"/> N/A (see Referral)</p>	<p>Referral</p> <p><input type="checkbox"/> no referral</p> <p><input type="checkbox"/> medical practitioner</p> <p><input type="checkbox"/> physiotherapist</p> <p><input type="checkbox"/> ambulance transport</p> <p><input type="checkbox"/> hospital (private car)</p> <p><input type="checkbox"/> helicopter</p> <p><input type="checkbox"/> other</p> <hr/> <p>Provisional severity assessment</p> <p><input type="checkbox"/> mild (1-7 days modified activity)</p> <p><input type="checkbox"/> moderate (8-21 days modified activity)</p> <p><input type="checkbox"/> severe (>21 days modified or lost)</p> <p>Treating person</p> <p><input type="checkbox"/> medical practitioner</p> <p><input type="checkbox"/> first aid provider</p> <p><input type="checkbox"/> other</p> <p>.....</p> <p>Name of Medical Service Provider:</p> <p>.....</p> <hr/> <p>Form Completed By:</p> <p><input type="checkbox"/> Same as Previous Page</p> <p>Or</p> <p>Name:</p> <p>Date:</p> <p>Role:</p> <p>Signature:</p>
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