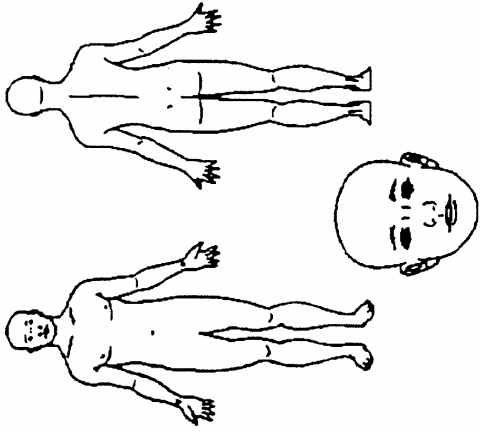


SPORTS INJURY TRACKER

www.sportsinjurytracker.com.au

Name of patient: _____ DOB ____/____/____ Date of Injury: ____/____/____
 Sex: Male Female Time ____:____:____ am/pm Sport _____

The injured person is: Player Referee Coach Spectator Patient Address: _____ Postcode _____
 Patient phone number: _____ Venue _____ Event/match _____

<p>Type of activity at time of injury</p> <p><input type="checkbox"/> training <input type="checkbox"/> warm-up <input type="checkbox"/> competition <input type="checkbox"/> cool-down <input type="checkbox"/> other _____</p> <p>Reason for Presentation</p> <p><input type="checkbox"/> new injury <input type="checkbox"/> exacerbated/aggravated injury <input type="checkbox"/> recurrent injury <input type="checkbox"/> illness <input type="checkbox"/> other _____</p> <p>Body Region Injured Tick or circle body part/s injured & name</p> <div style="text-align: center;">  </div> <p>Body part/s</p> <p>_____</p> <p>_____</p>	<p>Nature of Injury/Illness</p> <p><input type="checkbox"/> abrasion/graze <input type="checkbox"/> sprain eg ligament tear <input type="checkbox"/> strain eg muscle tear <input type="checkbox"/> open wound/laceration/cut <input type="checkbox"/> bruise/contusion <input type="checkbox"/> inflammation/swelling <input type="checkbox"/> fracture (including suspected) <input type="checkbox"/> dislocation/subluxation <input type="checkbox"/> overuse injury to muscle or tendon <input type="checkbox"/> blisters <input type="checkbox"/> concussion <input type="checkbox"/> cardiac problem <input type="checkbox"/> respiratory problem <input type="checkbox"/> loss of consciousness <input type="checkbox"/> unspecified medical condition <input type="checkbox"/> other _____</p> <p>Provisional diagnosis/es</p> <hr/> <p>Mechanism of Injury</p> <p><input type="checkbox"/> struck by other player <input type="checkbox"/> struck by ball or object <input type="checkbox"/> collision with other player/referee <input type="checkbox"/> collision with fixed object <input type="checkbox"/> fall/stumble on same level <input type="checkbox"/> jumping to shoot or defend <input type="checkbox"/> fall from height/awkward landing <input type="checkbox"/> overexertion (eg muscle tear) <input type="checkbox"/> overuse <input type="checkbox"/> slip/trip <input type="checkbox"/> temperature related eg heat stress <input type="checkbox"/> other _____</p>	<p>Explain exactly how the incident occurred: _____</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>Protective Equipment 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>Initial Treatment</p> <p><input type="checkbox"/> none given (not required) <input type="checkbox"/> RICER <input type="checkbox"/> dressing <input type="checkbox"/> sling, splint <input type="checkbox"/> crutches <input type="checkbox"/> CPR <input type="checkbox"/> stretch/exercises <input type="checkbox"/> taping only <input type="checkbox"/> none given - referred elsewhere <input type="checkbox"/> other _____</p> <p>Advice Given</p> <p><input type="checkbox"/> Immediate return, unrestricted activity <input type="checkbox"/> Able to return with restriction <input type="checkbox"/> Unable to return at the present time <input type="checkbox"/> Able to return but the player chose not to <input type="checkbox"/> Referred for further assessment before returning to activity</p>
<p>Referral</p> <p><input type="checkbox"/> no referral <input type="checkbox"/> medical practitioner <input type="checkbox"/> physiotherapist <input type="checkbox"/> ambulance transport <input type="checkbox"/> hospital <input type="checkbox"/> other _____</p> <p>Provisional severity assessment</p> <p><input type="checkbox"/> mild (1-7 days modified activity) <input type="checkbox"/> moderate (8-21 days modified activity) <input type="checkbox"/> severe (>21 days modified or lost)</p> <p>Treating person</p> <p><input type="checkbox"/> medical practitioner <input type="checkbox"/> sports trainer (ID _____) <input type="checkbox"/> other _____</p> <p><input type="checkbox"/> I have provided the patient with a copy of this report. I told the patient that this record will be kept for insurance purposes. The injury information will be entered into the Sports Injury Tracker Tool to monitor injuries that occur in sport to help to create a safer environment for the future.</p> <p>Treating Persons Name</p> <p>_____</p> <p>Signature _____</p> <p>For more information about Sports Injury Tracker call 03 9674 8777</p>		