

Injury Details: This report reflects an accurate record of the patient's reported symptoms of injury		
Name of person injured:		DOB: / / (Day/Month/Year)
Date when injury occurred: / /		Date when injury is evident: / /
Person injured: <input type="checkbox"/> Athlete <input type="checkbox"/> Coach <input type="checkbox"/> Other:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Supervising Coach: _____ (Signature)		Witness: _____ (Signature)
First Aid provided by: _____ (Signature)	Date of First Aid: / /	Initial Treatment: <input type="checkbox"/> No treatment required or requested <input type="checkbox"/> CPR <input type="checkbox"/> RICER <input type="checkbox"/> Crutches <input type="checkbox"/> Sling/splint <input type="checkbox"/> Dressing <input type="checkbox"/> Strapping <small>Note: Coaches without medical training should refer all medical and treatment decisions to appropriately qualified persons.</small>
Reason for presentation:	<input type="checkbox"/> New Injury <input type="checkbox"/> Aggravated Injury <input type="checkbox"/> Recurrent Injury <input type="checkbox"/> Other:	
Where did the injury occur?		
<input type="checkbox"/> Training <input type="checkbox"/> Event <input type="checkbox"/> Other:		
Reported or visible symptoms of Injury: <input type="checkbox"/> Blisters <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Pain <input type="checkbox"/> Blood Nose <input type="checkbox"/> Fracture/Break (<i>inc. suspected</i>) <input type="checkbox"/> Poisoning <input type="checkbox"/> Bruising/Contusion <input type="checkbox"/> Graze/Abrasion <input type="checkbox"/> Respiratory Problem <input type="checkbox"/> Burn <input type="checkbox"/> Heavy bleeding <input type="checkbox"/> Spinal <input type="checkbox"/> Cardiac problem <input type="checkbox"/> Inflammation /Swelling <input type="checkbox"/> Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Infection <input type="checkbox"/> Strain <input type="checkbox"/> Cut/Laceration <input type="checkbox"/> Insect Bite/Sting <input type="checkbox"/> Tenderness <input type="checkbox"/> Discolouration <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Other <input type="checkbox"/> Dislocation <input type="checkbox"/> Open wound/laceration <input type="checkbox"/>		
Body part injured: 	How did the injury occur? <input type="checkbox"/> Collision with fixed object e.g. vaulting horse <input type="checkbox"/> Overbalance <input type="checkbox"/> Collision with another person <input type="checkbox"/> Overstretch <input type="checkbox"/> Fall from height/awkward landing <input type="checkbox"/> Slip/trip <input type="checkbox"/> Fall /stumble on same level e.g. mats <input type="checkbox"/> Other:	
	Explain how the injury occurred as reported: 	
	Names of any witnesses: 	
	Was protective equipment worn on the injured site? <input type="checkbox"/> Yes <input type="checkbox"/> No e.g. hand guard, footwear	
	<input type="checkbox"/> No referral <input type="checkbox"/> Medical Practitioner/Physiotherapist <input type="checkbox"/> Hospital <input type="checkbox"/> Ambulance <input type="checkbox"/> Other:	
Signature of person completing form:		Date: / /

Note:

Coaches without medical training should refer all medical and treatment decisions to appropriately qualified persons. Any person who administers treatment should not do so other than in accordance with their own expertise and training.

Users of this form are advised that all medical information should be treated confidentially, in-line with Commonwealth Privacy Act 1998.

Be advised additional legislation affects the management of health records in some states. Eg. Victoria has legislation defining the use of Health Records (Health Records Act 2001).

Search on <http://www.austlii.edu.au>. Send a copy of this report to the insurer within the policy period. Coaches can refer to the Risk Management