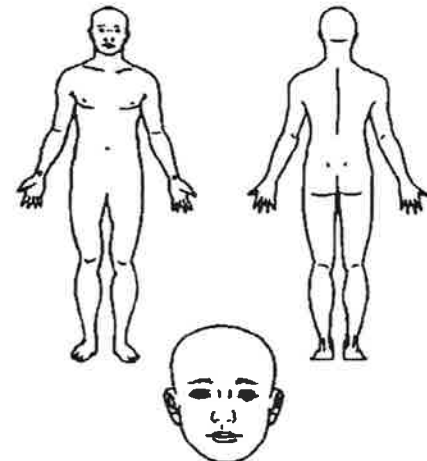


FOOTBALL (SOCCER) INJURY REPORTING FORM

Name: _____ Initials: _____ Position: _____ **Circle** Player/Referee/Coach/Spectator
 Team: _____ Grade: _____ DOB: ___/___/___ Gender: M F Venue/area at which injury occurred: _____

<p>Date of Injury ___/___/___</p> <p>Type of activity at time of injury</p> <p><input type="checkbox"/> training/practice <input type="checkbox"/> competition <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> <p>_____</p> <p style="text-align: center;">CAUSE OF INJURY</p> <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"/> heading ball <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>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</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>_____</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, taping, shin guard.</p> <p>_____</p> <p>_____</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"/> massage <input type="checkbox"/> manual therapy <input type="checkbox"/> CPR <input type="checkbox"/> stretch/exercises <input type="checkbox"/> strapping/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 present time</p> <p>Referral</p> <p><input type="checkbox"/> no referral <input type="checkbox"/> medical practitioner <input type="checkbox"/> physiotherapist <input type="checkbox"/> chiropractor or other professional <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"/> physiotherapist <input type="checkbox"/> nurse <input type="checkbox"/> sports trainer <input type="checkbox"/> other _____</p> <p>Signature of treating person</p> <p>_____</p> <p>_____</p> <p>Today's Date: ___/___/___</p>
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