

NET BALL INJURY REPORTING FORM

Name: _____
 Team: _____

Division: _____ DOB: _____

Gender: M F

Circle - Player / Umpire / Coach / Spectator
 Venue at which injury occurred: RAY OWEN

Date of Injury

Type of activity at time of injury

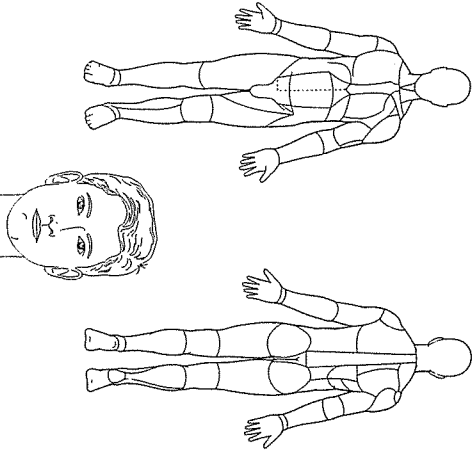
- Training/Practise
- Competition
- Other _____

Reason for Presentation

- New injury
- Exacerbated/aggravated injury
- Recurrent injury
- Illness
- Other _____

Body Region Injured

Tick or circle body part/s injured & name



Body Parts

Nature of Injury/Illness

- Abrasion/graze
- Sprain eg ligament tear
- Strain eg muscle tear
- Open wounded/acceleration/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 ball or object
- Collision with other player/referee
- Collision with fixed object
- Fall/stumble on same level
- Jumping to shoot, defend/rebound
- Fall from height/awkward landing
- Gradual onset, no specific mechanism identified
- Slip/trip
- 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.

Initial Treatment

- None given (not required)
- 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
- 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

- First Aid Officer
- Medical practitioner
- Physiotherapist
- Nurse
- Sports trainer
- Other _____

Signature of Treating Person

PRINT NAME _____

Today's Date: _____