BASKETBALL INJURY REPORTING FORM

Name: _____ Initials: _____ Position: _____ **Circle** Player/Referee/Coach/Spectator

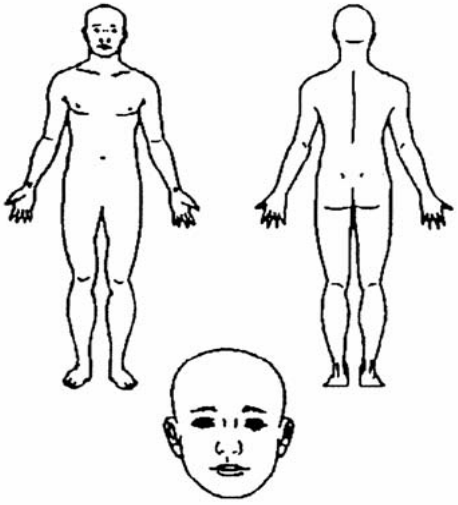
Team :_____ Grade: _____ DOB: __/__/__ Gender: M ☐ F ☐ Venue/area at which injury occurred: _____

Date of Injury __/__/__

Type of activity at time of injury
- ☐ training/practice
- ☐ 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 part/s
_____

_____

Nature of Injury/Illness
- ☐ abrasion/graze
- ☐ sprain eg ligament tear
- ☐ strain eg muscle tear
- ☐ open wound/laceration/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
- ☐ overexertion (eg muscle tear)
- ☐ overuse
- ☐ 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
- ☐ medical practitioner
- ☐ physiotherapist
- ☐ nurse
- ☐ sports trainer
- ☐ other _____

Signature of treating person
_____
_____

Today's Date: __/__/__