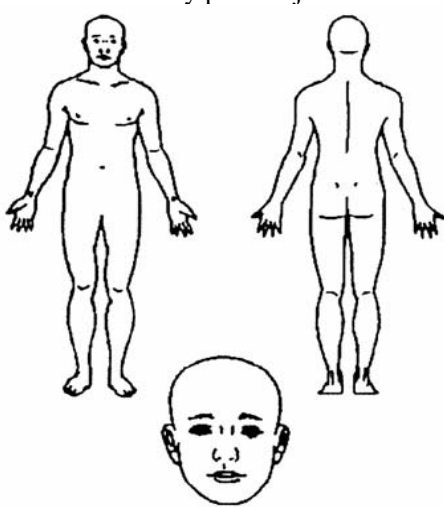


GYMNASTICS INJURY REPORTING FORM

Name: _____ Initials: _____ Position: _____ **Circle** Player/Referee/Coach/Spectator
 Level: _____ 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</p> <p><input type="checkbox"/> competition</p> <p><input type="checkbox"/> other _____</p> <p>Reason for Presentation</p> <p><input type="checkbox"/> new injury</p> <p><input type="checkbox"/> exacerbated/aggravated injury</p> <p><input type="checkbox"/> recurrent injury</p> <p><input type="checkbox"/> illness</p> <p><input type="checkbox"/> other _____</p> <p>Body Region Injured</p> <p>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</p> <p><input type="checkbox"/> sprain eg ligament tear</p> <p><input type="checkbox"/> strain eg muscle tear</p> <p><input type="checkbox"/> open wound/laceration/cut</p> <p><input type="checkbox"/> bruise/contusion</p> <p><input type="checkbox"/> inflammation/swelling</p> <p><input type="checkbox"/> fracture (including suspected)</p> <p><input type="checkbox"/> dislocation/subluxation</p> <p><input type="checkbox"/> overuse injury to muscle or tendon</p> <p><input type="checkbox"/> blisters</p> <p><input type="checkbox"/> concussion</p> <p><input type="checkbox"/> cardiac problem</p> <p><input type="checkbox"/> respiratory problem</p> <p><input type="checkbox"/> loss of consciousness</p> <p><input type="checkbox"/> unspecified medical condition</p> <p><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"/> collision with fixed object eg vaulting</p> <p><input type="checkbox"/> fall/stumble on same level eg on mats</p> <p><input type="checkbox"/> fall from height/awkward landing eg from apparatus or from jump</p> <p><input type="checkbox"/> slip/trip</p> <p><input type="checkbox"/> collision with other person</p> <p><input type="checkbox"/> overstretch</p> <p><input type="checkbox"/> overbalance</p> <p><input type="checkbox"/> overexertion (eg muscle tear)</p> <p><input type="checkbox"/> overuse</p> <p><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>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</p> <p>Was protective equipment worn on the injured body part? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If yes, what type eg wrist brace, taping.</p> <p>_____</p> <p>Initial Treatment</p> <p><input type="checkbox"/> none given (not required)</p> <p><input type="checkbox"/> RICER <input type="checkbox"/> dressing</p> <p><input type="checkbox"/> sling, splint <input type="checkbox"/> crutches</p> <p><input type="checkbox"/> massage <input type="checkbox"/> manual therapy</p> <p><input type="checkbox"/> CPR <input type="checkbox"/> stretch/exercises</p> <p><input type="checkbox"/> strapping/taping only</p> <p><input type="checkbox"/> none given - referred elsewhere</p> <p><input type="checkbox"/> other _____</p> | <p>Advice Given</p> <p><input type="checkbox"/> immediate return unrestricted activity</p> <p><input type="checkbox"/> able to return with restriction</p> <p><input type="checkbox"/> unable to return at present time</p> <p>Referral</p> <p><input type="checkbox"/> no referral</p> <p><input type="checkbox"/> medical practitioner</p> <p><input type="checkbox"/> physiotherapist</p> <p><input type="checkbox"/> chiropractor or other professional</p> <p><input type="checkbox"/> ambulance transport</p> <p><input type="checkbox"/> hospital</p> <p><input type="checkbox"/> other _____</p> <p>Provisional severity assessment</p> <p><input type="checkbox"/> mild (1-7 days modified activity)</p> <p><input type="checkbox"/> moderate (8-21 days modified activity)</p> <p><input type="checkbox"/> severe (>21 days modified or lost)</p> <p>Treating person</p> <p><input type="checkbox"/> medical practitioner</p> <p><input type="checkbox"/> physiotherapist</p> <p><input type="checkbox"/> nurse</p> <p><input type="checkbox"/> sports trainer</p> <p><input type="checkbox"/> other _____</p> <p>Signature of treating person</p> <p>_____</p> <p>_____</p> <p>Today's Date: __/__/__</p> |
|---|--|--|--|