Injury Report Form

Steward of meeting to SMS all injuries requiring a medical clearance to Garry LAMBERT on 0401 119 118 before 8am next business day.
In the event of a death please contact the local police, and SMS/Call details to G LAMBERT on 0401 119 118

Date / /	Time

Event and Incident Details

Event	
Permit No.	
Discipline	
Promoter	
Venue	

☐ Competitor	☐ Spectator
☐ Official	☐ Other
Class	Bike No #

Location / Turn #

Racing Stopped ☐ Yes ☐ No

Arrived at Medical Centre by
☐ Walk in ☐ FIV ☐ Ambulance ☐ Other

Injuries ☐ Yes ☐ No

Summary of Injuries.....

Medical Clearance Required ☐ Yes ☐ No

Referred to (name)

Transported to by
☐ Private Car ☐ Ambulance ☐ Helicopter

Form Completed By

Name

Organisation

Signature

Contact Number

Date / Time

Patient Details

Name

MA Licence Number

Date of Birth

Address

Phone Number

Emergency Contact person:

Medical Background
Concurrent Illnesses and Previous Operations

Tetanus UTD Y / N

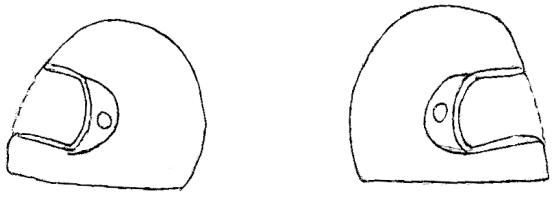
Current Medication

Allergies

BP	Heart Rate
GCS	SpO2 %

Relevant Presentation / Examination / Treatment Detail

Marks / impacts to helmet



DATE NAME INCIDENT FORM

INJURY REPORT FORM

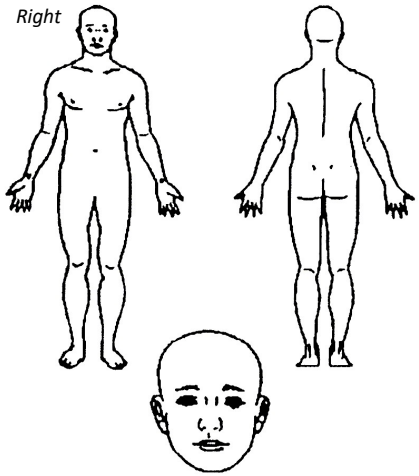
Patients Name:

.....

Type of activity at time of injury
☐ practice
☐ competition
☐ recreational
☐ 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 e.g. ligament tear
☐ strain e.g. muscle tear
☐ open wound/laceration/cut
☐ bruise/contusion
☐ inflammation/swelling
☐ dislocation/subluxation
☐ overuse injury to muscle or tendon
☐ blisters
☐ fracture (including suspected) *
☐ concussion *
☐ cardiac problem *
☐ respiratory problem *
☐ loss of consciousness *
☐ unspecified medical condition
☐ other .....

*** Automatic Licence Suspension**

Provisional diagnosis/es

_____

Mechanism of Injury
☐ High side
☐ Low side
☐ Impact
☐ Hit Wall / Barrier / Object
☐ Overexertion (eg muscle tear)
☐ Overuse
☐ Slip / Trip
☐ Temperature related eg. Heat stress

Other .....

☐ Jump
☐ High Speed
☐ Medium Speed
☐ Low Speed
Other .....

Protective Equipment
Was protective equipment worn on the injured body part? ☐ yes ☐ no

If yes, what type eg helmet, neck brace.....

Initial Treatment
☐ none given (not required)
☐ RICER ☐ dressing
☐ taping only ☐ crutches
☐ sling, splint ☐ stretch/exercises
☐ CPR
☐ none given - referred elsewhere

other .....

Advice Given
☐ Immediate return, unrestricted activity
☐ Able to return with restriction
☐ Unable to return at the present time
☐ Rider able to return but chose not to
☐ Referred for further assessment before returning to activity

_____

_____

Critical Incident?

☐ Yes ☐ No

If Yes, who is involved
☐ Police
☐ Coroner
☐ N/A (see Referral)

Referral
☐ no referral
☐ medical practitioner
☐ physiotherapist
☐ ambulance transport
☐ hospital (private car)
☐ helicopter
☐ 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
☐ first aid provider
☐ other

.....

Name of Medical Service Provider:

_____

Form Completed By:

☐ Same as Previous Page

Or

Name: .....

Date: .....

Role: .....

Signature: .....