

# MA INJURY REPORT FORM



Name of patient: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_ Date of Injury: \_\_/\_\_/\_\_ Time: \_\_\_\_\_:\_\_\_\_\_am/pm

Sex: Male  Female  Discipline: \_\_\_\_\_ The injured person is a: Rider  Official  Coach  Spectator  Other

Patient Address: \_\_\_\_\_ Postcode: \_\_\_\_\_ Phone: \_\_\_\_\_

Event: \_\_\_\_\_ Venue: \_\_\_\_\_ Bike No: \_\_\_\_\_ Turn Location: \_\_\_\_\_

<p><b>Type of activity at time of injury</b></p> <p><input type="checkbox"/> practice  <input type="checkbox"/> competition  <input type="checkbox"/> other _____</p> <p><b>Reason for Presentation</b></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><b>Arrived at medical centre by:</b></p> <p><input type="checkbox"/> Walk in <input type="checkbox"/> FIV <input type="checkbox"/> Ambulance          other: _____</p> <p><b>Body Region Injured</b></p> <p>Tick or circle body part/s injured &amp; name</p> <div style="text-align: center;"> <p>right</p> </div> <p><b>Body part/s</b></p> <p>_____</p> <p>_____</p>	<p><b>Nature of Injury/illness</b></p> <p><input type="checkbox"/> abrasion/graze  <input type="checkbox"/> sprain e.g. ligament tear  <input type="checkbox"/> strain e.g. 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><b>Provisional diagnosis/es</b></p> <hr/> <p><b>Mechanism of Injury</b></p> <p><input type="checkbox"/> high side / low side (<i>circle</i>)  <input type="checkbox"/> hit wall / barrier / object (<i>circle</i>)  <input type="checkbox"/> impact  <input type="checkbox"/> overexertion (e.g. muscle tear)  <input type="checkbox"/> overuse  <input type="checkbox"/> slip/trip  <input type="checkbox"/> temperature related e.g. heat stress</p> <p>Other _____</p> <p>jump          high speed          medium speed          low speed</p> <p>other _____</p>	<p>Explain exactly how the incident occurred:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Protective Equipment</b></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 helmet, neck brace, _____</p> <p><b>Initial Treatment</b></p> <p><input type="checkbox"/> none given (not required)          RICER                      dressing                                           sling, splint              crutches  <input type="checkbox"/> CPR    stretch/exercises                                           taping only                                           none given - referred elsewhere                                           other _____</p> <p><b>Advice Given</b></p> <p><input type="checkbox"/> Immediate return, unrestricted activity  <input type="checkbox"/> Able to return with restriction  <input type="checkbox"/> Unable to return at the present time  <input type="checkbox"/> Able to return but the rider chose not to  <input type="checkbox"/> Referred for further assessment before returning to activity</p> <p>_____</p> <p>_____</p> <p><b>Critical Incident?</b></p> <p><input type="checkbox"/> Yes              <input type="checkbox"/> No</p> <p>If Yes, who is involved:</p> <p><input type="checkbox"/> Police  <input type="checkbox"/> Coroner  <input type="checkbox"/> N/A (see to Referral)</p>	<p><b>Referral</b></p> <p><input type="checkbox"/> no referral  <input type="checkbox"/> medical practitioner  <input type="checkbox"/> physiotherapist  <input type="checkbox"/> ambulance transport  <input type="checkbox"/> hospital (private car)  <input type="checkbox"/> helicopter          Other _____</p> <p><b>Provisional severity assessment</b></p> <p><input type="checkbox"/> mild (1-7 days modified activity)  <input type="checkbox"/> moderate (8-21 days modified activity)  <input type="checkbox"/> severe (&gt;21 days modified or lost)</p> <p><b>Treating person</b></p> <p><input type="checkbox"/> medical practitioner  <input type="checkbox"/> first aid provider  <input type="checkbox"/> other _____</p> <p style="text-align: center;"><b>Medical Clearance Required</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes              <input type="checkbox"/> No</p> <hr/> <p><b>Treating Persons Name: (please print)</b></p> <p>_____</p> <p><b>Organisation:</b></p> <p><b>Contact no.:</b></p> <p><b>Signature</b> _____</p> <p>Comments (<i>continue over page if needed</i>)</p> <p>_____</p> <p style="text-align: right;"><i>Include in Stewards Forms</i></p>
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