Suspected Concussion Report Form

GENERAL INFORMATION

Player Name: _____ **DOB**: _____ **Sex:** ☐M ☐F ☐Unspecified
Club Name: _____ **Division**: _____ **Level:** ☐A ☐AA ☐AAA
Height: _____ **Weight**: _____ **Position**: ☐ Forward ☐ Defense ☐ Goalie

INJURY DESCRIPTION

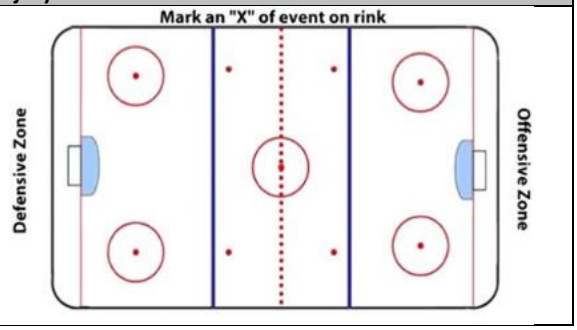
Date of injury: _____ **Time:**_____ **Date you were aware of suspected injury**:_____
Arena location: _____ **Opposing team**: _____

A) Initial injury scenario	B) Resulted in contact with	C) Was contact anticipated?
☐ Contact with Opponent	☐ Boards	☐ Yes
☐ Contact with Opponent (From Behind)	☐ Ice	☐ No
☐ Contact with Teammate	☐ Opponent's Body	☐ Unsure
☐ Fall	☐ Stick	**D) Was there a penalty called on play?**
☐ Other	☐Puck	☐ Yes
	☐ Net	☐ No
	☐ Other	☐ Unsure

E) Game Scenario	F) Period	G) Puck Possession	H) Score
☐ On ice practice	☐ 1st period	☐ Yes	☐ Winning
☐ Regular game	☐ 2nd period	☐ No	☐ Losing
☐ Exhibition	☐ 3rd period	☐ Just released	☐ Winning >2
☐ Tournament	☐ Overtime	☐ Other	☐ Losing >2
☐ Playoffs	☐ Other		☐ Tie Game
☐ Other _____			

Additional Comments:

I) Injury Location



REPORTED SYMPTOMS (*CHECK ALL THAT APPLY*)

☐ Visual problems	☐ Balance problems	☐ Drowsiness	☐ Irritability
☐ Nausea	☐ Feeling mentally foggy	☐ Sleeping more/less than usual	☐ Sadness
☐ Dizziness	☐ Feeling slowed down	☐ Trouble falling asleep	☐ Nervous/anxious
☐ Vomiting	☐ Difficulty concentrating	☐ Sensitive to light	☐ More emotional
☐ Headache	☐ Difficulty remembering	☐ Sensitive to noise	☐ Fatigue

RED FLAG SYMPTOMS (*CHECK ALL THAT APPLY*): *CALL 911 IMMEDIATELY WITH A SUDDEN ONSET OF ANY OF THESE SYMPTOMS*

☐Severe or increasing headache	☐ Neck pain or tenderness	☐ Seizure or convulsion
☐ Double vision	☐ Loss of consciousness	☐ Repeated vomiting
☐ Weakness or tingling/burning in arms/legs	☐ Deteriorating conscious state	☐ Increasingly restless, agitated or combative

Are there any <u>other</u> symptoms or evidence of injury to anywhere else? ☐Yes ☐No
If yes, what: _____

Has this player had a concussion before? ☐Yes ☐No ☐Prefer not to answer
If yes, how many: ☐1 ☐2 ☐3 ☐4 ☐>5 ☐ Unsure

Any pre-existing medical conditions or take any medications? ☐Yes ☐No ☐Prefer not to answer
If yes, please list:_____

I [*name of trainer completing this form*] _____recommended to player's parent/guardian that the player seek medical assessment as soon as possible. *A medical assessment must be from a family doctor, pediatrician, emergency room doctor, sports-medicine physician, physiatrist, neurologist or a nurse practitioner.*
Signature_____ Phone Number: _____
Email Address:_____

PLEASE NOTE: *This form is to be completed by the team trainer in the event of a <u>suspected</u> concussion in any Markham Waxers activity. Once this form is complete, give one copy of this report to parent/guardian and the other to head trainer.* ***EMAIL:*** ***<u>barbm.waxers@gmail.com</u>*** ***Parents are to take this form for medical assessment appointment***

Report form informed by NHL Heads-Up Checklist from Hutchison et al 2013

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