Hockey ACT
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Hockey ACT Injury Report Form

Participants, please complete this form following an injury. By completing this form you are consenting to the data being shared with your club, Hockey ACT and Hockey Australia.

If you have a confirmed or suspected concussion please complete the **Hockey Australia Concussion Report Form** instead.

If you require further information regarding insurance, see the **Insurance page** on the Hockey ACT website.

This survey is conducted in accordance with our Data Collection Privacy Policy. https://www.hockeyact.org.au/surveys/privacy

Contact email address

Basic Information

1. (Required) Injured person

2. (Required) Date & time

____/____/_____

3. (Required) Location/Venue of Incident

4. (Required) How did the injury occur? (Please tick ONE option)

- [ ] Collision with fixed object
- [ ] Collision with other person
- [ ] Fall/stumble
- [ ] Jumping
- [ ] Landing from jump
- [ ] Other
- [ ] Overexertion
- [ ] Overuse

- [ ] Slip/trip
- [ ] Struck by ball (e.g. dislocated finger)
- [ ] Struck by other player
- [ ] Temperature related (e.g. heat stress)
- [ ] Twisting to pass or accelerate

5. Description

6. Initial treatment given by

Member name

7. (Required) Referred to (Please tick ONE option)

- [ ] Ambulance
- [ ] Chiropractor
- [ ] Hospital
- [ ] Medical Practitioner
- [ ] None
- [ ] Other
- [ ] Physiotherapist

8. (Required) Action taken (Please tick ONE option)

- [ ] Immediate return to activity
- [ ] Able to return to activity but chose not to
- [ ] Referred for further assesment and then returned to activity
- [ ] Unable to return to activity

9. Ongoing management by (Please tick ONE option)

- [ ] Medical Practitioner
- [ ] Physiotherapist
- [ ] Nurse
- [ ] Sports Trainer
- [ ] Other

10. (Required) Impact assessment (Please tick ONE option)

- [ ] Mild (1-7 days modified activity)
- [ ] Moderate (8-21 days modified activity)
- [ ] Severe (>21 days modified activity)

11. Outcome

12. Progressed to insurance claim

- [ ]

Injury Details

13. (Required) Body Part (Please tick ONE option)

- [ ] Head
- [ ] Ear
- [ ] Nose
- [ ] Cheek
- [ ] Mouth and Lips
- [ ] Teeth
- [ ] Jaw
- [ ] Gums
- [ ] Eye

- [ ] Neck
- [ ] Shoulder
- [ ] Upper Arm
- [ ] Elbow
- [ ] Wrist
- [ ] Hand
- [ ] Thumb
- [ ] Index (2nd) Finger
- [ ] Middle (3rd) Finger
- [ ] Ring (4th) Finger
- [ ] Pinky (5th) Finger
- [ ] Chest (Thorax)
- [ ] Abdomen
- [ ] Pelvis
- [ ] Hip
- [ ] Thigh
- [ ] Knee
- [ ] Lower Leg
- [ ] Ankle
- [ ] Foot and Toes
- [ ] Back

14. (Required) Side (Please tick ONE option)

- [ ] N/A
- [ ] Left
- [ ] Right

15. (Required) Nature of injury (Please tick ONE option)

- [ ] Abrasion/graze

- [ ] Blisters
- [ ] Bruise/Contusion
- [ ] Cardiac problem
- [ ] Concussion
- [ ] Dislocation/subluxation
- [ ] Fracture/suspected fracture
- [ ] Inflammation/swelling
- [ ] Loss of consciousness
- [ ] Open wound/laceration/cut
- [ ] Other
- [ ] Overuse injury to muscle
- [ ] Respiratory problem
- [ ] Sprain (e.g. ligament tear)
- [ ] Strain (e.g. muscle tear)
- [ ] Unspecified medical condition

16. (Required) Protective equipment (Please tick ONE option)

- [ ] Box
- [ ] Braces/guards/orthoses
- [ ] Eye goggles
- [ ] Face mask
- [ ] Footwear
- [ ] Gloves
- [ ] Helmet
- [ ] Mouthguard
- [ ] None
- [ ] Other
- [ ] Padding

- [ ] Splints
- [ ] Taping

17. (Required) Previous history of similar injury

18. (Required) Initial treatment (Please tick ONE option)

- [ ] CPR
- [ ] Dressing
- [ ] Manual therapy
- [ ] Massage
- [ ] None given - not required
- [ ] None given - referred elsewhere
- [ ] RICER
- [ ] Sling/splint
- [ ] Strapping/taping
- [ ] Stretch/exercises