GTHL Suspected Concussion Report Form

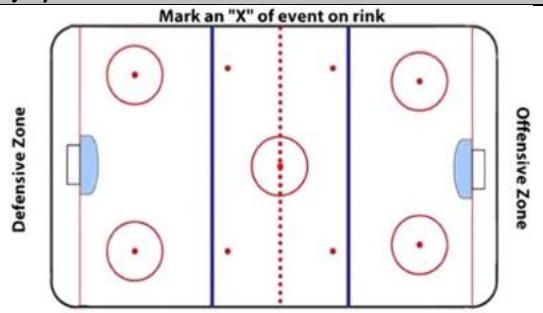
GENERAL INFORMATION

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?	General Information
☐ Contact with Opponent	☐ Boards	☐ Yes	**Was this a call up?**
☐ Contact with Opponent (From Behind)	☐ Ice	☐ No	☐ Yes
☐ Contact with Teammate	☐ Opponent's Body	☐ Unsure	☐ No
☐ Fall	☐ Stick	**D) Was there a penalty called on play?**	
☐ Other	☐Puck	☐ Yes	**Number of hours of physical activity player participated in today?**
	☐ Net	☐ No	
	☐ Other	☐ Unsure	_____

E) Game Scenario	F) Period	G) Puck Possession	H) Score	I) Injury Location
☐ 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:

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 immediately. *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 suspected concussion in any GTHL activity. Once complete, give one copy of this report to parent/guardian and the other to GTHL head office.* ***EMAIL:*** **MFATA@GTHLCANADA.COM** *or* ***FAX: 416-636-2035. Parents and players are to take this form to a medical assessment appointment.***

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

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