MATCH DAY HEAD INJURY
ASSESSMENT & REFERRAL FORM

SIDELINE FORM (to be completed by the examiner (first aider/trainer) on the day of the suspected concussion)

PLAYER NAME	CLUB

DETAILS OF INCIDENT

DATE

OCCURRED AT: ☐ MATCH ☐ TRAINING ☐ OTHER

BRIEF DESCRIPTION

1 IDENTIFICATION OF RED FLAGS
(tick all those that apply)

- Loss of consciousness ☐
- Seizure or convulsions ☐
- Deterioration of conscious state ☐
- Persistent or increasing vomiting ☐
- Double vision ☐
- Severe or increasing headache ☐
- Increasing restlessness, agitation, or combative behaviour ☐
- Neck pain ☐
- Weakness or tingling/burning in the arms or legs ☐

ACTION: If any one of the boxes above is ticked, an ambulance should be called for immediate transportation to hospital.

2 FEATURES OF A SUSPECTED CONCUSSION
(tick all those that apply)

- Loss of responsiveness ☐
- Motor incoordination (losing balance, staggering, etc) ☐
- Confused/disorientation (not aware of plays or events) ☐
- Impaired memory (unable to recall events before or after the injury) ☐
- Looking/feeling dazed, blank or vacant ☐
- Player reporting symptoms:
  - a. 'don't feel right' ☐
  - b. more emotional than usual – sad, nervous or anxious ☐
  - c. 'feel slowed down', confused or 'feel like in a fog' ☐
  - d. Sensitivity to light or noise ☐
- The player is not their normal self, or there is any other concern that they are not quite right ☐
- Other (please list):

ACTION: for any suspected concussion, the player needs to see a doctor as soon as practical for assessment, including confirmation of the diagnosis. The player must not return to play or full contact training until they have been cleared by a doctor.

EXAMINER NAME	ROLE AT CLUB
EXAMINER SIGNATURE	DATE

MATCH DAY HEAD INJURY
ASSESSMENT & REFERRAL FORM

PLAYER FORM (to be completed on the day of the suspected concussion)

PLAYER NAME	
CLUB	**AGE**
How many concussions have you had in the past?	
When was the most recent concussion?	
How long was the recovery (time to being cleared to play) for the most recent concussion? (approximate number of weeks)	

SCORE YOURSELF ON THE FOLLOWING SYMPTOMS, BASED ON HOW YOU FEEL RIGHT NOW.

	NONE		MILD		MODERATE		SEVERE
	0	1	2	3	4	5	6
Headache	○	○	○	○	○	○	◉
"Pressure in head"	○	○	○	○	○	○	○
Neck Pain	○	○	○	○	○	○	○
Nausea or vomiting	○	○	○	○	○	○	○
Dizziness	○	○	○	○	○	○	○
Blurred vision	○	○	○	○	○	○	○
Balance problems	○	○	○	○	○	○	○
Sensitivity to light	○	○	○	○	○	○	○
Sensitivity to noise	○	○	○	○	○	○	○
Feeling slowed down	○	○	○	○	○	○	○
Feeling like "in a fog"	○	○	○	○	○	○	○
"Don't feel right"	○	○	○	○	○	○	○
Difficulty concentrating	○	○	○	○	○	○	○
Difficulty remembering	○	○	○	○	○	○	○
Fatigue or low energy	○	○	○	○	○	○	○
Confusion	○	○	○	○	○	○	○
Drowsiness	○	○	○	○	○	○	○
Trouble falling asleep	○	○	○	○	○	○	○
More emotional	○	○	○	○	○	○	○
Irritability	○	○	○	○	○	○	○
Sadness	○	○	○	○	○	○	○
Nervous or Anxious	○	○	○	○	○	○	○

PLAYER SIGNATURE	DATE

(Please take a copy of both the sideline and player form with you to your visit to the doctor)