# Concussion Referral & Clearance Form

| SECTION 1 DETAILS OF INJURED PERSON (please print clearly) | |
|---|---|
| **TEAM OFFICIAL TO COMPLETE** (Manager, Coach or First Aid / Healthcare practitioner*) **AT THE TIME/ON THE DAY OF THE INJURY, BEFORE PRESENTING TO HEALTHCARE PRACTITIONER REVIEWING THE PLAYER** | |
| Name of player: | Date of Birth: |
| Sport: | Club/School: |

Dear Healthcare Practitioner,

This person has presented to you today because they were injured on (day & date of injury) _____ in a (game or training session) _____ and suffered a potential head injury or concussion.

| **The injury involved:** (select one option) | | |
|---|---|---|
| ☐ Direct head blow or knock | ☐ Indirect injury to the head e.g. whiplash injury | ☐ No specific injury observed |

| **The subsequent signs or symptoms were observed (Please select one or more):** Consult the referee/umpire if no signs and symptoms were observed by team official personnel | | |
|---|---|---|
| ☐ Loss of consciousness | ☐ Dazed or vacant stare | ☐ Ringing in the ears |
| ☐ Disorientation | ☐ Headache | ☐ Fatigue |
| ☐ Incoherent speech | ☐ Dizziness | ☐ Vomiting |
| ☐ Confusion | ☐ Difficulty concentrating | ☐ Blurred vision |
| ☐ Memory loss | ☐ Sensitivity to light | ☐ Loss of balance |
| ☐ Other: _____ | | |

| | |
|---|---|
| Is this their first concussion in the last 12 months? ☐ Yes ☐ No | |
| If NO, how many concussions in the last 12 months: | |
| Name: | Role: |
| Signature: | Date: |

| **INJURED PERSON or PARENT / LEGAL GUARDIAN CONSENT** (for persons under 18 years of age) | | |
|---|---|---|
| I _____ (insert name) consent to _____ (insert Healthcare Practitioner's name) providing information if required to my Club/School regarding my head injury and confirm that the information I have provided the doctor has been complete and accurate. | | |
| Name: | Signature: | Date: |

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## SECTION 2 - INITIAL CONSULTATION

**HEALTHCARE PRACTITIONER IDEALLY WOULD SEE THE INJURED PERSON WITHIN 72 HOURS OF THE INJURY**

**AIS recommends that all persons who have suffered a concussion or a suspected concussion must be treated as having suffered concussion.**

The person has been informed that they must be referred to a healthcare practitioner. **Your role as a healthcare practitioner is to assess the person and guide their progress over the remaining steps in the process.**

Detailed guidance for you, the healthcare practitioner, on how to manage concussion can be found at the Concussion in Australian Sport website www.concussioninsport.gov.au

Please note, any person who has been diagnosed showing signs and symptoms of concussion MUST follow the Graduated Return to Sport Framework (GRTSF) https://www.concussioninsport.gov.au/__data/assets/pdf_file/0006/1133466/GRADED-RETURN-TO-SPORT-FRAMEWORK-COMMUNITY-AND-YOUTH.pdf

**FOR CHILDREN & ADOLESCENTS AGED UNDER 19, AND ADULTS IN COMMUNITY (NON-ELITE) SPORT, THE ATHLETE MUST BE SYMPTOM FREE FOR 14 DAYS BEFORE RETURN TO ANY CONTACT TRAINING. THE MINIMUM TIME FOR RETURN TO COMPETITIVE CONTACT IS 21 DAYS.**

I have assessed the person and I have read and understood the information above.

| Healthcare Practitioner's Name: | |
|---|---|
| Signed: | Date: |

## SECTION 3 - CLEARANCE APPROVAL

I (healthcare practitioner's name) _____ have reviewed _____ (persons name) today and based upon the evidence presented to me by them and their family / support person, and upon my history and physical examination I can confirm:

- I have reviewed Section 1 of this form and specifically the mechanism of injury and subsequent signs and symptoms
- The person has been symptom-free for at least 14 days
- The person will not return to competitive contact in less than 21 days from the time of concussion
- The person has completed the Graduated Return to Sport Framework process without evoking any recurrence of symptoms
- The person has returned to school, study or work normally and has no symptoms related to this activity

I also confirm that I have read the Australian Concussion Guidelines for Youth and Community Sport https://www.concussioninsport.gov.au/__data/assets/pdf_file/0003/1133994/37382_Concussion-Guidelines-for-community-and-youth-FA-acc.pdf

I therefore approve that this person may return to full contact training and if they successfully complete contact training without recurrence of symptoms, the person may return to playing sport (competitive contact).

| Healthcare Practitioner's Name: | |
|---|---|
| Signature: | Date: |

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