

# GTHL Suspected Concussion Report Form

## GENERAL INFORMATION


Player Name: _____	DOB: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unspecified
Club Name: _____	Division: _____	Level: <input type="checkbox"/> A <input type="checkbox"/> AA <input type="checkbox"/> AAA
Height: _____	Weight: _____	Position: <input type="checkbox"/> Forward <input type="checkbox"/> Defense <input type="checkbox"/> 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?
<input type="checkbox"/> Contact with Opponent	<input type="checkbox"/> Boards	<input type="checkbox"/> Yes
<input type="checkbox"/> Contact with Opponent (From Behind)	<input type="checkbox"/> Ice	<input type="checkbox"/> No
<input type="checkbox"/> Contact with Teammate	<input type="checkbox"/> Opponent's Body	<input type="checkbox"/> Unsure
<input type="checkbox"/> Fall	<input type="checkbox"/> Stick	D) Was there a penalty called on play?
<input type="checkbox"/> Other	<input type="checkbox"/> Puck	<input type="checkbox"/> Yes
	<input type="checkbox"/> Net	<input type="checkbox"/> No
	<input type="checkbox"/> Other	<input type="checkbox"/> Unsure

E) Game Scenario	F) Period	G) Puck Possession	H) Score	I) Injury Location
<input type="checkbox"/> On ice practice	<input type="checkbox"/> 1 <sup>st</sup> period	<input type="checkbox"/> Yes	<input type="checkbox"/> Winning	<div style="text-align: center;">Mark an "X" of event on rink</div> 
<input type="checkbox"/> Regular game	<input type="checkbox"/> 2 <sup>nd</sup> period	<input type="checkbox"/> No	<input type="checkbox"/> Losing	
<input type="checkbox"/> Exhibition	<input type="checkbox"/> 3 <sup>rd</sup> period	<input type="checkbox"/> Just released	<input type="checkbox"/> Winning >2	
<input type="checkbox"/> Tournament	<input type="checkbox"/> Overtime	<input type="checkbox"/> Other	<input type="checkbox"/> Losing >2	
<input type="checkbox"/> Playoffs	<input type="checkbox"/> Other		<input type="checkbox"/> Tie Game	
<input type="checkbox"/> Other _____				
<b>Additional Comments:</b>				

## REPORTED SYMPTOMS (CHECK ALL THAT APPLY)

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

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

<input type="checkbox"/> Severe or increasing headache	<input type="checkbox"/> Neck pain or tenderness	<input type="checkbox"/> Seizure or convulsion
<input type="checkbox"/> Double vision	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Repeated vomiting
<input type="checkbox"/> Weakness or tingling/burning in arms/legs	<input type="checkbox"/> Deteriorating conscious state	<input type="checkbox"/> Increasingly restless, agitated or combative

Are there any other 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 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](mailto:MFATA@GTHLCANADA.COM) or FAX: 416-636-2035. Parents and players are to take this form to a medical assessment appointment.