Queensland Representative School Sport

Appendix 3: Concussion Referral and Return Form

SECTION 1 *MUST be completed by designated first aid officer / team official at the representative school sport event at the time / on the day of the injury (if none present, a team official) to provide to the doctor who is treating the student.*

SECTION 1 – STUDENT & INCIDENT DETAILS (please print clearly)		
NOTE: If the initial assessment has not been fully completed prior to transferring care of student to paramedic/parent/carer, place a line through any incomplete assessment tables, complete the Signature block, and pass the form to the paramedic/parent/carer to provide to the treating medical practitioner.		
Name of student:	**Date of birth:**	
Region/District/School:	**Competition:**	
Venue of incident:	**Date & time of incident:**	
The injury involved: *(select one option)*	Direct blow or knock to the head	☐
	Indirect injury to the head e.g.: whiplash/ translational force	☐
	No specific injury observed	☐
Specific details of incident:		

INITIAL ASSESSMENT: Remember DR ABC

Provide **EMERGENCY FIRST AID** as dictated by the situation. Please note if you observe any of the following signs:	
unconscious and not breathing	☐
unconscious but breathing normally (e.g. Lying motionless on the field)	☐
vomiting	☐
having a seizure	☐
expelling blood/clear fluid from ear/nose	☐
unequally dilated pupils	☐
deformity of skull	☐

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Complete Observation tables A and B.

Observation table A If emergency first aid is not required, immediately after the incident, observe and/or question the student and record if they have any of the following immediate signs/symptoms (answer YES or NO to all):			
Blank or vacant look:	YES/NO	Disorientation or confusion, or an inability to respond appropriately to questions	YES/NO
Severe or increasing headache:	YES/NO	Increasingly restless, agitated or combative:	YES/NO
Slow to get up after a direct/indirect knock to the head:	YES/NO	Balance, gait difficulties, motor incoordination, stumbling, slow laboured movements:	YES/NO

Observation table B While monitoring the student, observe and/or question the student and record if they report any of the following symptoms (please answer YES or NO to all):			
Headache:	YES/NO	Blurred vision:	YES/NO
Dizzy:	YES/NO	Sensitivity to light:	YES/NO
Drowsy:	YES/NO	Sensitivity to noise:	YES/NO
Nausea:	YES/NO	Difficulty concentrating:	YES/NO
Balance problems:	YES/NO	Difficulty remembering:	YES/NO
Neck pain:	YES/NO	Fatigue/ low energy/feeling slowed down:	YES/NO
Feeling like 'in a fog':	YES/NO	More emotional/ 'Don't feel right':	YES/NO
Nervous/anxious:	YES/NO	More irritable:	YES/NO
Neck pain or tenderness:	YES/NO	Sadness:	YES/NO
Weakness or tingling/burning in arms/legs:	YES/NO		

Other relevant information: e.g. History of previous concussion	

Signature block	
Name:	**Role (Please circle):** *Official / Coach / Teacher / First Aid Officer / Sport Medical Personnel / Doctor on Duty / Other*:
Signature:	**Date:**

Form provided to:	Paramedic ☐ Parent/carer ☐ Other ☐ _____

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SECTION 2 – RETURN TO EVENT CLEARANCE

MUST be completed by the treating doctor following medical assessment of the student who has been suspected of sustaining a concussion.

SECTION 2 (A) – MEDICAL ASSESSMENT	
(Student name) _____ has presented to me for medical assessment/treatment as a result of the incident/injuries detailed in Section 1 of this form.	
Based on my assessment of the player and the information provided to me it is my medical opinion that the player named above:	
☐ ***has probably NOT*** had a concussion.	*Complete SECTION 2(B) and SECTION 2(C)*
☐ ***has*** had a concussion; OR ☐ ***has* probably** had a concussion.	*Complete SECTION 2(C) and SECTION 3*

SECTION 2 (B) – CLEARANCE & APPROVAL
I am a doctor (qualified medical practitioner). ☐ I **directly witnessed** the incident or viewed video footage of the incident; OR ☐ I did **not witness** the incident directly or view video footage. I have examined and assessed the player in conjunction with the information provided in **SECTION 1** of this Appendix 3: Concussion Referral and Return Form and determine that the signs /symptoms documented on this form were exhibited as a result of: _____ In my medical opinion the player has **NOT** suffered a concussion in this instance and the player is **cleared to return to full participation** in _____ (insert sport) from _____ (insert date and time).

SECTION 2 (C) MEDICAL PRACTITIONER DETAILS	
Name:	Medical Practice (stamp or details):
Signature:	

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SECTION 3 – RETURN TO LEARN AND SPORT CARE PLANS

Treating doctor to complete Sections 3 (A) -(C) to help the student's school to support the student's learning needs and return to sport.

Note: Specific concussion management advice for sports offered by Queensland representative school sports are available in the Concussion Management Guideline, Appendix 2: Concussion management resource for individual sports.

Dear school staff,

(Name)_____(DOB)_____has sustained a concussion/mild head injury on (date)_____. They can return to school on (date)_____.

Concussion affects the way the brain functions. Different people can be affected in different ways. It is common for concussed children or adolescents to have difficulty concentrating in class and they will not perform as well as usual in exams and assessments. They may require more time to complete work. When a concussed child or adolescent starts to concentrate for long periods, it is not unusual for symptoms to increase. These can usually be managed by frequent breaks and short rests in quiet areas.

Advise the parent and family to seek medical attention if the student displays concerning symptoms such as severe headache, seizure, weakness or increasing drowsiness.

SECTION 3 (A): RETURN TO LEARN CARE PLAN
I recommend the following:

Graduated return to school	Suggested return to learn timeframe	Doctor's recommendation
1. Daily activities at home Typical daily activities, such as reading or gentle walking. Begin with 5 to 15 minutes at a time and gradually build up.	Usually 1 -2 days off school	
2. School activities at home Introduce homework, school reading etc at home.	Usually in first week	
3. Return to school part time May need to start with a shorter school day or have increased breaks during the day. Note: School tests may need to be delayed.	Usually after 1-2 days	
4. Return to school full time Gradually increase school activities until student can tolerate a full day.	Usually by 1-2 weeks	

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SECTION 3 (B): RETURN TO SPORT CARE PLAN	
Graduated return to sport	**Doctor's recommendation**
1. Symptom-limited activity Simple daily activities that do not provoke symptoms by more than 30%.	
2. Light aerobic exercise Gradually increase walking, swimming or stationary cycling at a slow to medium pace. Do not allow resistance training.	
3. Sport-specific exercise Begin activities such as running, warm-up drills and practicing ball skills (with a soft ball). Do not allow any activities that involve head contact.	
4. Non-contact training drills Introduce harder training drills, such as passing drills. Your child may start progressive training. (This usually takes 1-2 weeks).	
5. Full contact practice Following medical clearance, participate in normal training activities. (Follow up GP appointment is required).	
6. Return to sport Progress to normal game play.	

SECTION 3 (C) MEDICAL PRACTITIONER DETAILS	
Name:	Medical Practice (stamp or details):
Signature:	