## **SGHL Suspected Concussion Reporting Form**

## GENERAL INFORMATION Player Name: DOB: **Position**: ☐ Forward ☐ Defense ☐ Goalie Team Name: INJURY DESCRIPTION Date of injury: \_\_\_ Time: Date you were aware of suspected injury: Opposing team: Arena: B) Resulted in contact with C) Was contact anticipated? A) Initial injury scenario ☐ Contact with Opponent ☐ Boards ☐ Yes ☐ Contact with Opponent (From Behind) □ No ☐ Contact with Teammate ☐ Opponent's Body ☐ Unsure D) Was there a penalty called on play? ☐ Fall ☐ Stick ☐ Other □ Puck □ Net $\square$ No ☐ Other ☐ Unsure G) Puck Possession E) Game Scenario F) Period I) Injury Location ☐ On ice practice ☐ 1<sup>st</sup> period ☐ Yes ☐ Regular game ☐ 2<sup>nd</sup> period □ No ☐ Exhibition ☐ 3<sup>rd</sup> period ☐ Just released Defensive Zone □ Tournament □ Overtime ☐ Other ☐ Other ☐ Playoffs □ Other **Additional Comments:** REPORTED SYMPTOMS (CHECK ALL THAT APPLY) ☐ Visual problems ☐ Balance problems □ Drowsiness ☐ Irritability ☐ Feeling mentally foggy ☐ Sadness □ Nausea ☐ Sleeping more/less than usual □ Dizziness ☐ Feeling slowed down ☐ Trouble falling asleep ☐ Nervous/anxious ☐ Vomiting ☐ Difficulty concentrating ☐ Sensitive to light ☐ More emotional ☐ Difficulty remembering ☐ Sensitive to noise ☐ Fatigue ☐ Headache RED FLAG SYMPTOMS (CHECK ALL THAT APPLY): CALL 911 IMMEDIATELY WITH A SUDDEN ONSET OF ANY OF THESE SYMPTOMS ☐ Severe or worsening headache ☐ Neck pain or tenderness ☐ Seizure or convulsion ☐ Double vision ☐ Loss of consciousness ☐ Repeated vomiting ☐ Weak/numb or tingling/burning in arms/legs ☐ Deteriorating conscious state ☐ Increasingly restless, agitated or combative ☐ Slurred speech ☐ Worsening confusion 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: $\Box 1 \ \Box 2 \ \Box 3 \ \Box 4 \ \Box > 5$ □Unsure Any pre-existing medical conditions or take any medications? □Yes □No □Prefer not to answer If yes, please list: I [name of coach 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 physician (i.e., family doctor, pediatrician, emergency room doctor, sportsmedicine physician, physiatrist, neurologist) or a nurse practitioner. Signature Phone Number:

**PLEASE NOTE:** This form is to be completed by the team coach in the event of a suspected concussion in any SGHL activity. Once complete, give one copy of this report to parent/guardian and the other to SGHL Director of Health & Safety **EMAIL:** <a href="mailto:league@sghl.ca">league@sghl.ca</a>. **Parents and players are to take this form to a medical assessment appointment.** 

**Email Address:** 

## Figure 1. Remove-From-Sport Protocol Summary

REMOVE: A suspected concussion has been recognized and player is removed from play. Coaches hold the final decision to remove players with a suspected concussion. REPORT: Coach completes Suspected Concussion Reporting Form. Provides copy to: Parent/Guardian and recommend they seek SGHL: league@sqhl.ca medical assessment as soon as possible REFER: See a medical doctor or nurse practitioner for medical assessment\* If player is experiencing any concussion If player is experiencing any 'Red Flag' **Symptoms:** symptoms: Severe or increasing headache Physical: Headaches, nausea, dizziness, sensitivity Double vision to light and noise Weakness/numbness or tingling/burning in arms/legs Neck pain or tenderness Mental: Fogginess and difficulty thinking, feeling slowed Loss of consciousness down, difficulty concentrating and remembering Deteriorating conscious state Sleep: Sleeping more or less than usual, difficulty falling Seizure or convulsion asleep and staying asleep Repeated vomiting Increasingly restless, agitated or combative Emotional and Behavioural: Sadness, anger, Slurred speech frustration, nervousness/anxious, irritable Worsening confusion <u>\*Includes</u>: Family Physician, Schedule an appointment as Call 9-1-1 Pediatrician, Sports-Medicine soon as possible with a Go to nearest Physician, Physiatrist, Neurologist or medical doctor/nurse Emergency pracitioner.\* Go to nearest Nurse Practitioner. Department **Emergency Department if** Recommend Medical Assessment 'Red Flag' symptoms appear Letter template be completed ASSESS: Was concussion diagnosis received at medical or emergency appointment? Parent/guarding provide medical Parent monitors for 24-48 hrs in YES NO documentation of diagnosis to coach case symptoms appear or worsen Send medical documentation of no RECOVERY AND GRADUAL diagnosis to coach to send to SGHL BEFORE on-ice activity **RETURN-TO-SPORT:** Enter Stage 1 of return-to-sport protocol **RETURN-TO-SPORT**