Concussion Referral and Clearance Form

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| **SECTION 1 – DETAILS OF PERSON COMPLETING THE FORM** (please print clearly) |
| Sections 1 & 2 to be completed by the trainer, ringside doctor or contestant at the time/on the day of the injury and before presenting to a healthcare practitioner reviewing the fighter. |
| Name of person completing this report: Role (i.e. trainer, doctor, fighter): |
| Phone number: Email: |

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| **SECTION 2 – DETAILS OF INJURED FIGHTER** | |
| Name of injured fighter: | Date of Birth: |
| Phone number: | Email: |

Dear Healthcare Practitioner,

This person has presented to you today because they were injured on (date of injury) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in a (describe setting i.e.

training session/ contest) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and suffered a potential concussion/suspected concussion.

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

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| **The subsequent signs or symptoms were observed** (select all that apply): | | | | | |
|  | Loss of consciousness (less than 1 minute) |  | Loss of consciousness (more than 1 minute) |  | 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 the first concussion the contestant has had in the last 2 years? Yes No | | | | | |
| If NO, how many concussions has the contestant had in last 2 years? | | | | | |

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| **Injured person consent** |  |  |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert name) consent to a healthcare practitioner providing information if required to the Professional Boxing and Combat Sports Board of Victoria regarding my head injury and confirm that the information I have provided to the doctor has been complete and accurate. | | |
| Name: | Signature: | Date: |

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| **Section 3 – INITIAL CONSULTATION** | |
| A HEALTHCARE PRACTITIONER IDEALLY WOULD SEE THE INJURED PERSON WITHIN 72 HOURS OF THE INJURY | |
| **The Professional Boxing and Combat Sports Board recommends that all persons who have suffered a concussion or suspected concussion be treated as having a 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 Sports website<https://www.concussioninsport.gov.au/medical_practitioners>.  **Please note, any person who has been diagnosed as showing signs and symptoms of concussion MUST follow the Professional Boxing and Combat Sports Board Graduated Return to Fight Strategy via the Professional Boxing and Combat Sports Board website-** ([Non-fight periods and return to fight strategy | Contestant safety | Boxing and Combat Sports | Department of Jobs, Skills, Industry and Regions](https://djsir.vic.gov.au/combat-sports/contestant-safety/non-fight-periods-and-return-to-fight-strategy)).  **I have assessed the person, and I have read and understand the information above.** | |
| Medical Practitioner’s Name: | APHPRA Registration Number: |
| Contact Phone Number: | Email Address: |
| Signed: | Date: |

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| **SECTION 4 – CLEARANCE APPROVAL (to be completed by a medical practitioner)** | |
| I (medical practitioner’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  have reviewed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of fighter) and based upon the evidence presented to me by them and their trainer (if appropriate), and upon my history and physical examination, I can confirm:   * I have reviewed Section 2 of this form and specifically the mechanism of injury and subsequent signs and symptoms * The person has been symptom-free for at least 30 days. * The person will not return to contact sparring in less than 30 days from the date of concussion * The person has completed the Professional Boxing and Combat Sports Board’s Graduated Return to Fight Strategy (stages 1 -3) without evoking any recurrence of symptoms * The person has returned to work or study normally and has no symptoms related to this activity.   I therefore approve that this person may return to contact sparring/training and if they successfully complete contact sparring/training for a period of 7 days without the recurrence of symptoms, the person may return to fight/competition. | |
| Medical Practitioner’s Name: | AHPRA Registration Number: |
| Contact Phone Number: | Email Address: |
| Signature: | Date: |

This report is to be completed and returned to the Combat Sports Unit via email [combat.sports@sport.vic.gov.au](mailto:combat.sports@sport.vic.gov.au) once complete.

The fighter will not be cleared to return to fight/competition until Section 4 of this form, **Clearance Approval,** has been provided by a medical practitioner.