WEST AUSTRALIAN FOOTBALL COMMISSION INC.

WA FOOTBALL
CONCUSSION REFERRAL & CLEARANCE FORM

SECTION 1: DETAILS OF THE INJURED PLAYER

Team Official to complete (Manager, First Aid, Sports Trainer, Coach) at the time/on the day of the injury, before presenting to the Healthcare Practitioner reviewing the player.

Name of Player: _____

Date of Birth: _____ Club: _____

Day & Date of Injury: _____ Level / Grade of Competition: _____

Game or Training Session: _____ Oval Name: _____

The above player was assessed using the Concussion Recognition Tool 6 (CRT6) or a SCAT6 and showed signs / symptoms of a potential head injury or a concussion.

The Injury involved: (select one option)

- ☐ Direct head blow or knock
- ☐ Indirect injury to the head or body e.g. whiplash injury
- ☐ No specific injury observed

If observed, provide a short description of how the injury occurred: _____

_____

_____

The subsequent signs or symptoms were observed (please select one or more):
Consult the umpire or others if no specific injury was observed by team officials

- ☐ Loss of Consciousness
- ☐ Confusion
- ☐ Headache
- ☐ Sensitivity to light or noise
- ☐ Vomiting
- ☐ Disorientation
- ☐ Memory Loss
- ☐ Dizziness
- ☐ Ringing in the ears
- ☐ Blurred vision
- ☐ Incoherent Speech
- ☐ Dazed or vacant stare
- ☐ Difficulty concentrating
- ☐ Fatigue
- ☐ Loss of balance

Other: _____

Were any **RED FLAGS** observed? ☐ Yes ☐ No

If any of these **RED FLAGS** are observed, then refer immediately to the closest Emergency Department

- ☐ Neck pain
- ☐ Deteriorating conscious state
- ☐ Unusual behavioral change
- ☐ Loss of consciousness
- ☐ Repeated vomiting
- ☐ Severe or increasing
- ☐ Loss of vision or double vision
- ☐ Increasing confusion, agitation or irritability
- ☐ Seizure or convulsion
- ☐ Headache
- ☐ Visible deformity of the skull
- ☐ Weakness or tingling/burning in the arms or legs

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Was the player referred immediately to the Emergency Department? ☐ Yes ☐ No

Does the player have a previous history of concussion?

Is this their first concussion in the past 12 months? ☐ Yes ☐ No

If NO, how many concussions in the past 12 months? _____

What was the date (approximate) of their last concussion? _____

How long (in weeks) did it take them to Return to Play following their last concussion? _____

Name: _____ Role: _____

Signature: _____ Date: _____

Please take a photo of this sheet for your and the clubs records and provide this form to the player or parent / guardian.

Injured Person or Parent / Legal Guardian Consent (for persons under 18 years of age)

I _____ (insert name) consent to _____ (insert Healthcare Practitioners name) providing information if required to my club/league/school regarding my head injury or concussion and confirm that the information I have provided the doctor has been complete and accurate.

Name: _____ Signature: _____ Date: _____

SECTION 2: HEALTHCARE PRACTITIONER CONSULTATION

A Healthcare Practitioner ideally would see the injured player within 72 hours of the injury

WA Football recommends that all players who have suffered a concussion or a suspected concussion **MUST** be treated as having suffered concussion.

The player has been informed that they must be referred to a Healthcare Practitioner. **Your role as a Healthcare Practitioner is to assess the individual 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 – https://www.concussioninsport.gov.au/medical_practitioners

Please note: Any person who has been diagnosed with a concussion or is suspected of having a concussion MUST follow the Graduated Return to Sport Framework – https://www.concussioninsport.gov.au/__data/assets/pdf_file/0006/1133466/GRADED-RETURN-TO-SPORT-FRAMEWORK-COMMUNITY-AND-YOUTH.pdf

The Player **MUST** be symptom free for 14 days before returning to any contact or collision training. The minimum time for a Return to Play (games/competitive contact) is 21 days.

I can confirm that the player I have seen has been provided with:

☐ Advice regarding Return to Play protocols & symptom management.
Follow up appointment to provide medical clearance to return to contact training once symptom free for 14 days.

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

☐ Following a review of Section 1 of this report, and my subsequent assessment of the player, my diagnosis is that the player **WAS NOT** concussed and is fit to Return to Play.

Healthcare Practitioner's Name: _____

Practice Name: _____ Provider #: _____

Signed: _____ Date: _____

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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 games / contact less than 21 days from the time of concussion.
- ☐ The person has completed the Graduated Return to Sport Framework process without exacerbating / 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 and understand the Concussion in Sport Position Statement / Framework that is available via https://www.concussioninsport.gov.au/medical_practitioners

- ☐ I also confirm that I am an AHPRA registered health care practitioner that has appropriate training and experience in concussion assessment and management to make this assessment.

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 with competitive contact not less than 21 days from the time of the concussion.

Please Note: *An official medical clearance on practice letterhead is also required.*

Healthcare Practitioner's Name: _____

Practice Name: _____ Provider #: _____

Signed: _____ Date: _____

SECTION 4: PLAYER / GUARDIAN SIGN OFF

I, _____ (player / guardian name) have fully recovered from the symptoms of concussion, and I am healthy and fit to resume contact training. I have presented to an appropriate healthcare practitioner and provided them with complete and accurate information on my initial symptoms and subsequent recovery and have been medically cleared to return to contact training. I will not commence competitive contact (games) prior to 21 days post my concussion.

Signature: _____ Date: _____

SECTION 5: CLUB SIGN OFF

The _____ Football Club (name of club) are aware that _____ (name of player) has undertaken a graduated Return to Play process following a concussion, and have sighted the medical certificate as required. The above Healthcare Practitioner sign off has been completed and the player has been approved to Return to Contact training (noting that this must not be prior to 14 days post injury). We also acknowledge that the player will not return to competitive games prior to 21 days post their concussion. As far as the club is aware, the player has completed all requirements under the WA Football Return to Play protocols.

Name: _____ Position at Club: _____

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