CONCUSSION INCIDENT REPORT

CLEAR FORM

Follow the steps on the CATT Concussion Pathway, then document the incident below.

This incident form was completed by:

NAME:

ORGANIZATION:

CONTACT INFORMATION:

DATE (DD/MM/YYYY):

Did you witness the event?

- ☐ Yes
- ☐ No

NAME AND CONTACT OF ADDITIONAL WITNESSES:

Please indicate who you are completing this report for; who will receive this incident report? Please check all that apply:

- ☐ Injured person
- ☐ Emergency contact
- ☐ Ambulance attendant
- ☐ Healthcare professional (please specify):
- ☐ Supervisor/Employer
- ☐ Teacher/School
- ☐ Coach/Sports organization
- ☐ Other (please specify):

ABOUT THE INCIDENT

DATE OF INCIDENT (DD/MM/YYYY):

LOCATION OF INCIDENT:

TIME OF INCIDENT:

☐ AM ☐ PM

NAME OF INJURED PERSON:

NAME OF EMERGENCY CONTACT:

CONTACT INFO OF INJURED PERSON:

CONTACT INFO OF EMERGENCY CONTACT:

Describe the incident. Please include as much detail as possible:

Did the incident involve any of the following? Please check all that apply:

- ☐ Blow to the head
- ☐ Hit to the body
- ☐ Assault
- ☐ Motor vehicle collision
- ☐ Fall
- ☐ Struck by object
- ☐ Struck by person
- ☐ Sport-related
- ☐ Other:

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Continue to document the incident on next page >>

What was the immediate response to the incident? Please check all that apply:

- ☐ Called 911
- ☐ Called emergency contact
- ☐ Performed first aid
- ☐ No response
- ☐ Other:

What was the immediate outcome of the incident? Please check all that apply:

- ☐ Taken to hospital by ambulance
- ☐ Attended to by paramedics
- ☐ Left with emergency contact
- ☐ Left independently
- ☐ Returned to activity
- ☐ Other:

Did the person exhibit any immediate signs or symptoms of concussion?

☐ Yes ☐ No ☐ Don't know

If yes, check all that apply:

- ☐ Neck pain or tenderness
- ☐ Double Vision
- ☐ Weakness or tingling/burning in arms or legs
- ☐ Severe or increasing headache
- ☐ Seizure or convulsion
- ☐ Loss of consciousness
- ☐ Deteriorating conscious state
- ☐ Vomiting
- ☐ Increasingly restless, agitated or combative
- ☐ Imbalance
- ☐ Irritability
- ☐ Poor memory
- ☐ Sadness
- ☐ Confusion
- ☐ Headache
- ☐ Dizziness
- ☐ Nausea
- ☐ Blurred vision
- ☐ Light/sound sensitivity
- ☐ Ringing in the ears
- ☐ Seeing "stars"
- ☐ Fogginess
- ☐ Fatigue
- ☐ Difficulty concentrating
- ☐ Other:

To be filled out by administration only

Did this incident result in a concussion diagnosis?

☐ Yes ☐ No ☐ Don't know

Could this incident have been prevented?

☐ Yes ☐ No ☐ Don't know

Please describe any follow-up actions that have been taken (e.g., safety risk assessment):

Please describe how this incident could or could not have been prevented:

Please describe any follow-up actions that are needed (e.g., policy change to ensure health and safety):