APPENDIX 6

Concussion Referral and Return Form

In the event a player has been removed from play due to a suspected concussion, the Concussion Referral and Return form must be completed as specified by IHNSW.

This form is available for online submission at **www.ihnsw.com.au/concussion**

Sections 1 – 3 must be provided to the clubs Concussion Coordinator and IHNSW Executive Officer before full contact training and playing resumes.

FAILURE TO COMPLETE ANY SECTION OF THIS FORM WILL RESULT IN THE PLAYER BEING EXCLUDED FROM FULL CONTACT TRAINING AND PLAYING.

SECTION 1 - PLAYER DETAILS

Team official (manager, coach, medic) to complete at the time of the day of the injury, before presenting to medical doctor reviewing the player.

Player Name:

Date of Birth: DD/MM/YYYY

Club:

Competition:

Dear Doctor,

This ice hockey player has presented to you today because they were injured on: DD/MM/YYYY
in a (please tick) ☐ game/ ☐ training session and suffered a potential head injury or concussion.

The injury involved (select only one option)

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

The following subsequent signs or symptoms were observed (select all that apply):

Consult with the match officials if no symptoms were observed by team staff

☐ Loss of consciousness	☐ Difficulty concentrating	☐ Disorientation
☐ Sensitivity to light	☐ Incoherent speech	☐ Ringing in the ears
☐ Confusion	☐ Fatigue	☐ Memory loss
☐ Vomiting	☐ Dazed or vacant stare	☐ Blurred vision
☐ Headache	☐ Loss of balance	☐ Dizziness

Other (please specify)

Is this the first suspected concussion in the past 12 months? ☐ YES ☐ NO ☐ UNKNOWN

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

I have completed this form to the best of my knowledge on the suspicion that this given player has a suspected concussion.

Name:

Role:

Signature:

Date: DD/MM/YYYY

SECTION 2 – INITIAL CONSULTATION

Ice Hockey NSW takes concussion seriously and its default position is that all players who are suspected of, or have suffered, a concussion must be treated as having suffered concussion.

The player has been informed that they must be referred to a medical doctor. Your role as a medical doctor is to assess the player and guide their progress over the remaining steps in the process.

The IHNSW Concussion Policy and Graduated Return to Play Protocol is available in full at **www.ihnsw.com.au/concussion.**

Please note, any player who has been diagnosed showing signs and symptoms of concussion MUST follow the Graduated Return to Play (GRTP) protocol.

ADULTS AGED 19 AND OVER
The MINIMUM period before RETURN TO PLAY is 12 days

CHILDREN AND ADOLESCENTS AGED 18 AND UNDER
The MINIMUM period before RETURN TO PLAY is 19 days

I have assessed the player and read and understood the information provided about the incident in this form. I have provided a summary of my assessment in a written document attached.

Doctor's name:

Contact details:

Signature:

Date: DD/MM/YYYY

SECTION 3 – CLEARANCE APPROVAL

Doctor's name:

Players name:

Today and based upon the evidence presented to me by them and their parent / guardian, 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 player has undertaken the age specific mandatory rest period
- The player has completed steps 2,3,4 of the IHNSW Graduated Return to Play process without reoccurring symptoms
- The player has returned to school, study, work normally and has no symptoms related to this

I can also confirm I have read all relevant information in Ice Hockey NSW's Concussion Policy at **www.ihnsw.com.au/concussion.**

Following medical assessment, and completion of the above steps, I therefore approve that this player may return to full contact training (Stage 5 of the Graduated Return to Play) and if they complete this stage successfully without the reoccurrence of symptoms, the player may return to playing Ice Hockey.

Doctor's name:

Contact details:

Signature:

Date: DD/MM/YYYY