TSA Suspected Concussion Report Form

Holland Bloorview Kids Rehabilitation Hospital | Concussion Centre

Player Name: _____ Player DOB: _____

Date & Time of Injury: _____ Club Name: _____

Division: _____Level: _____ Game/Practice Location: _____ Sex: M F

Position during Injury (please circle): Defense Midfield Forward Goalie

Injury Description: Player to player contact ☐ Ball to player contact☐ Fall to ground ☐ Other ☐

Reported Symptoms (*Check all that apply):*

☐ Headache	☐ Feeling mentally foggy	☐ Sensitive to light
☐ Nausea	☐ Feeling slowed down	☐ Sensitive to noise
☐ Dizziness	☐ Difficulty concentrating	☐ Irritability
☐ Vomiting	☐ Difficulty remembering	☐ Sadness
☐ Visual problems	☐ Drowsiness	☐ Nervous/anxious
☐ Balance problems	☐ Sleeping more/less than usual	☐ More emotional
☐ Numbness/Tingling	☐ Trouble falling asleep	☐ Fatigue

Red Flag Symptoms (*Check all that apply): Call 911 immediately with a sudden onset of any of these symptoms*

☐ Headaches that worsen	☐ Can't recognize people or places	**Was 911 called?** ☐Yes ☐No
☐ Seizures or convulsions	☐ Increasing confusion or irritability	
☐Repeated vomiting	☐ Weakness or numbness in arms/legs	
☐ Loss of consciousness	☐ Persistent or increasing neck pain	
☐ Looks very drowsy/can't be awakened	☐ Unusual behavioural change	
☐Slurred speech	☐ Focal neurologic signs (e.g. paralysis, weakness, etc.)	

Are there any <u>other</u> observable/reported symptoms? ☐Yes ☐No

If yes, what: _____

Is there evidence of injury to anywhere else on body besides head? ☐Yes ☐No

If yes, where: _____

Has this player had a concussion before? ☐ Yes ☐ No ☐ Don't know ☐ Prefer not to answer

If yes, how many: _____

Does this player have any pre-existing medical conditions? ☐Yes ☐No ☐Don't know ☐Prefer not to answer

If yes, please list: _____

Does this player take any medication? ☐Yes ☐No ☐Don't know ☐Prefer not to answer

☐If yes, please list: _____

I [*name of coach completing this form*]: _____ recommended to the player's parent or guardian that the player sees a medical doctor/nurse practitioner immediately. *This includes a family doctor, pediatrician, emergency room doctor, sports-medicine physician, neurologist or nurse practitioner.*

Signature_____ Date:_____ Role:_____

Phone Number: _____ Email Address: _____

PLEASE NOTE: *This form is to be completed by the head coach in the event of a <u>suspected</u> concussion in <u>any TSA soccer activity</u>. Once complete, give one copy of this report to parent/guardian and the other to the TSA head office. Parents must take this form to a medical professional immediately.*