CONCUSSION INCIDENT REPORT

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
- Supervisor/Employer
- Emergency contact
- Teacher/School
- Ambulance attendant
- Coach/Sports organization
- ER physician
- Other (write below):

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

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Version 4: Updated May 2019.

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

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

Could this incident have been prevented?

Yes No Don't know

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

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

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