

**CONCUSSION REFERRAL & RETURN FORM**

This Concussion Referral & Return Form **MUST** be completed as specified by *Rugby Australia Concussion Procedure*.

**NOTE: THIS IS A LEGAL DOCUMENT AND UPON COMPLETION (Sections 1-3) MUST BE PROVIDED TO THE COMPETITION MANAGER BEFORE A PLAYER RETURNS TO FULL CONTACT TRAINING AND PLAYING.**

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

**SECTION 1 - PLAYER DETAILS** *(please print clearly)*

**TEAM OFFICIAL TO COMPLETE (Manager, Coach or First Aid / Medical Officer) AT THE TIME/ON THE DAY OF THE INJURY, BEFORE PRESENTING TO MEDICAL DOCTOR REVIEWING THE PLAYER**

Name of player:	Date of Birth:
Club/School:	Competition/State:

Dear Doctor,

This rugby player has presented to you today because they were injured on (day & date of injury) \_\_\_\_\_ in a (game or training session) \_\_\_\_\_ and **suffered a potential head injury or concussion.**

The Injury involved: (select one option)	Direct head blow or knock	<input type="checkbox"/>
	Indirect injury to the head e.g. whiplash injury	<input type="checkbox"/>
	No specific injury observed	<input type="checkbox"/>

The subsequent signs or symptoms were observed (Please select one or more)  
Consult the referee if no signs and symptoms were observed by team official personnel

Loss of consciousness: <input type="checkbox"/>	Difficulty Concentrating: <input type="checkbox"/>
Disorientation: <input type="checkbox"/>	Sensitivity to light: <input type="checkbox"/>
Incoherent Speech: <input type="checkbox"/>	Ringing in the ears: <input type="checkbox"/>
Confusion: <input type="checkbox"/>	Fatigue: <input type="checkbox"/>
Memory Loss: <input type="checkbox"/>	Vomiting: <input type="checkbox"/>
Dazed or Vacant Stare <input type="checkbox"/>	Blurred vision <input type="checkbox"/>
Headache: <input type="checkbox"/>	Loss of balance: <input type="checkbox"/>
Dizziness: <input type="checkbox"/>	Other: _____

Is this their first concussion in the last 12 months? (Please Circle)      YES      NO  
If NO, how many concussions in the last 12 months: \_\_\_\_\_

Name:	Signature:	Role:	Date:
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**PLAYER or PARENT / LEGAL GUARDIAN CONSENT (for players under 18 years of age)**

I \_\_\_\_\_ (insert name) consent to Dr. \_\_\_\_\_ (insert Doctor's name) providing information if required to Rugby Australia concussion consultant regarding my head injury and confirm that the information I have provided the doctor has been complete and accurate.

Name:	Signature:	Date:
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## SECTION 2 - INITIAL CONSULTATION – MEDICAL DOCTOR

**Rugby Australia takes concussion seriously and its default position is 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 medical doctor. **Your role as a medical doctor is to assess the player and guide their progress over the remaining steps in the process.**

Detailed guidance for you, the medical doctor, on how to manage concussion can be found in Rugby Australia's Concussion Management Medical Doctor information at <http://rugbyaustralia.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) programme.

**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 I have read and understood the information above and confirm I have read Rugby Australia's Concussion Management Medical Doctor Information.

<b>DOCTORS NAME:</b>	
<b>SIGNED:</b>	
<b>DATE:</b>	

## SECTION 3 - CLEARANCE APPROVAL – MEDICAL DOCTOR

**DOCTOR TO COMPLETE** *(please print clearly)*

I (Doctor's Name) \_\_\_\_\_ have reviewed \_\_\_\_\_ (players 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 Player has undertaken the age specific mandatory rest period
- The Player has completed steps 2, 3 and 4 of Rugby Australia's Graduated Return to Play process without evoking any recurrence of symptoms
- The Player has returned to school, study or work normally and have no symptoms related to this

I also confirm that I have read Rugby Australia's Concussion Management Medical Doctor document - <http://rugbyaustralia.com.au/concussion>

I therefore approve that this player may return to full contact training (Stage 5 of the Graduated Return To Play) and if they successfully complete this without recurrence of symptoms, the player may return to playing Rugby.

**Doctors Name:**

**Signature:**

**Date:**