

Personal Injury Report

Race

EP-109



Office Use:

DRIVER'S NAME

STEWARD SIGNATURE

SECRETARY SIGNATURE

SIGN HERE

SIGN HERE

Organisers are responsible for the completion of this form and in all cases at Motorsport Australia authorised events where any person suffers an injury and/or any person is given medical attention by first aid or medical personnel.

Additional reports (eg. Vehicle damage and/or incident reports) must be attached to this form. Always complete page 1, and pages 3 and 4 if injury is suspected. Complete page 2 if this form also acts as the medical record.

The form must be signed by the medical personnel or doctor on page 4 and both the Secretary and Steward on page 1.

Injured's Details		TIME IN	TIME OUT
SURNAME		GIVEN NAME/S	
DATE OF BIRTH	— —	GENDER	
ADDRESS		SUBURB	
STATE	POSTCODE	EMAIL	
PHONE	MOTORSPORT AUSTRALIA ID (If applicable)		
CAR NUMBER (If applicable)	ROLE AT EVENT	DRIVER	CO-DRIVER
		OFFICIAL	PIT CREW
		SPECTATOR	
		OTHER (PLEASE SPECIFY)	

Event Details				INCIDENT DETAILS
VENUE				Include turn number, impact severity, damage etc.
EVENT		PERMIT NUMBER		
DATE	— —	TIME OF INCIDENT		
SESSION OF EVENT	TESTING	PRACTICE	QUALIFYING	
	RACING	DEMONSTRATION		
	OTHER (please specify)			

Collision and Response Details						
MIV SCRAMBLED?	YES	NO	WAS SPEED A CONTRIBUTING FACTOR?	YES	NO	
RACING STOPPED/RED FLAG?	YES	NO	NO. OF CARS INVOLVED?			
RACING MODIFIED?	YES	NO	FIRE IN CAR?	YES	NO	
ASSESSED AT SCENE?	YES	NO	ENTRAPMENT?	YES	NO	
ASSESSED AT MEDICAL CENTRE?	YES	NO	LOSS OF CONSCIOUSNESS?	YES	NO	
AMBULANCE REQUIRED?	YES	NO	ARRIVAL METHOD OF INJURED PERSON	ON FOOT	CAR	AMBULANCE
INJURY SUSPECTED UPON EXAMINATION?	YES	NO	If YES, complete remainder of form as appropriate. If NO, sign below. If suspended or transported to hospital, email medical.notifications@motorsport.org.au			

Statement by Attending Doctor/Authorised Medical Personnel		
THE COMPETITORS LICENCE:	NAME	
SHOULD* SHOULD NOT	POSITION	
...BE SUSPENDED PENDING FURTHER EXAMINATION.	SIGNATURE	
*Note: if medical personnel consider licence should be suspended, it is to be immediately submitted to the Stewards of the Event with this form.	DATE	
	—	—

SIGN HERE

Continue to complete remainder of form as appropriate, ONLY if **YES**, was selected to 'Injury suspected upon examination?' on previous page.

History

Physical Findings

INDICATE PHYSICAL FINDINGS ON THE DIAGRAMS

Use these descriptions:

P - Pain

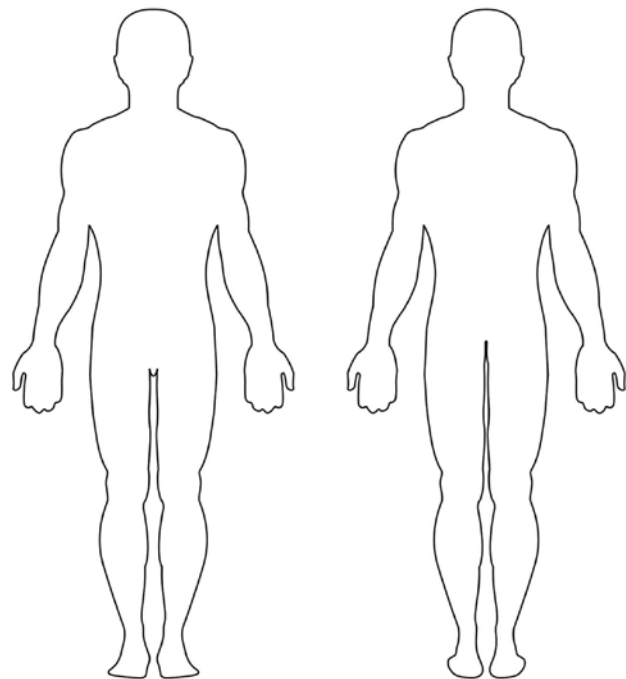
- Fracture

B - Burn

Lacn - Laceration

STI - Soft Tissue Injury - Superficial abrasion/bruise/ muscle tenderness/ligamentous injury

Otherwise, describe findings and include arrows



FRONT

BACK

Equipment Damage

HELMET DAMAGE

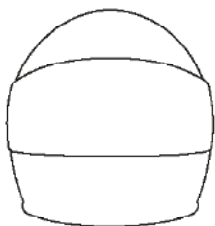
EXTENSIVE

MODERATE

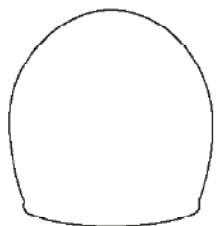
MINIMAL

NIL

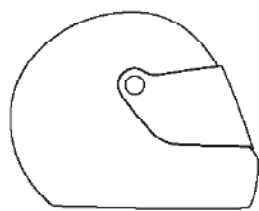
Indicate helmet damage (if any) on the diagrams



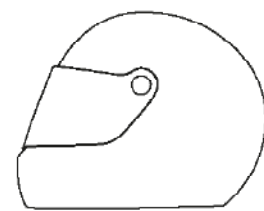
FRONT



BACK



RIGHT



LEFT

FHR DEVICE WORN?

YES

NO

FHR TETHERS DAMAGED?

YES

NO

Initial Findings

Only complete when form acts as a Medical Record

	Time					
	hrs	hrs	hrs	hrs	hrs	hrs
Pulse						
Respirations						
Blood Pressure						
CRT (Capillary Refill Time - in seconds)						
Saturation						
Pain (0-10)						
Pupil Size (+/-)	R L	R L	R L	R L	R L	R L
GCS (Glasgow Coma Score - Max. score: 15)						

GCS POINT CALCULATION

Eye opening: 4 - Spontaneous; 3 - To voice; 2 - To pain; 1 - None
Verbal response: 5 - Oriented; 4 - Confused; 3 - Inappropriate; 2 - Incomprehensible; 1 - No verbal response
Motor response: 6 - Obeys; 5 - Localises; 4 - Withdraws; 3 - Flexion; 2 - Extension 1 - No motor response

Initial Findings

Only complete when form acts as a Medical Record

AIRWAY	Clear	Obstructed						
	O ² via Mask %		OP airway	Ventilate	ET Tube	Size		
CX SPINE	Normal	Suspected injury	Collar	Spinal immobilization				
BREATHING	Adequate	Compromised	Absent					
	Spontaneous	Rate	SpO ² %					
CHEST	Normal sound	Flail	Pneumothorax	Tension	Haemothorax			
DISABILITY	Loss of consciousness	YES	NO					
CIRCULATION	B/P o/a		Haemorrhage	External/Site				
				Internal	Chest	Abdo (Suspected)	Pelvis	
IV ACCESS	Site 1		Size					
	Site 2		Size					
HISTORY		MEDICATIONS		ALLERGIES				

Summary Details

TRANSFERRED TO HOSPITAL

YES

NO

If **YES**, how was the patient transported?

CAR

AMBULANCE

AIR AMBULANCE

OTHER (PLEASE SPEC-
IFY)

CONDITION ON INITIAL PRESENTATION

WHAT (IF ANY) TREATMENT WAS PERFORMED

SUBSEQUENT TREATMENT RECOMMENDED

SUBSEQUENT TREATMENT RECOMMENDED

URGENT

NON URGENT

REVIEW, When:

HOME REST

OWN DOCTOR

HOSPITAL

OTHER

Attending Doctor/Authorised Medical Personnel

NAME

POSITION

SIGNATURE

SIGN HERE

DATE

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