Personal Injury Report - Race Events

Form: EP-109

CAMS Use:

DRIVER'S NAME

STEWARD SIGNATURE SIGN HERE

SECRETARY SIGNATURE SIGN HERE

Organisers are responsible for the completion of this form and in all cases at CAMS 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 & 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

SURNAME | **GIVEN NAME/S**

DATE OF BIRTH __ __ – __ __ – __ __ __ __ | **GENDER**

ADDRESS

PHONE | **EMAIL**

CAMS ID (If applicable) | **CAR NUMBER** (If applicable)

ROLE AT EVENT ☐ DRIVER ☐ CO-DRIVER ☐ OFFICIAL ☐ PIT CREW ☐ SPECTATOR

☐ OTHER (PLEASE SPECIFY)

Event Details

VENUE

EVENT | **PERMIT NUMBER**

DATE __ __ – __ __ – __ __ __ __ | **TIME OF INCIDENT**

SESSION OF EVENT ☐ TESTING ☐ PRACTICE ☐ QUALIFYING ☐ RACING ☐ DEMONSTRATION

☐ OTHER (PLEASE SPECIFY)

Collision and Response Details

FIV SCRAMBLED?	☐ YES ☐ NO	**WAS SPEED A CONTRIBUTING FACTOR?**	☐ YES ☐ NO
RACING STOPPED?	☐ 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.

Statement by Attending Doctor/Authorised Medical Personnel

THE COMPETITORS LICENCE:

☐ SHOULD* ☐ SHOULD NOT

...BE SUSPENDED PENDING FURTHER EXAMINATION.

*Note: if medical personnel consider licence should be suspended, it is to be immediately submitted to the Stewards of the Meeting with this form.

NAME

SIGNATURE SIGN HERE

DATE __ __ – __ __ – __ __ __ __

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

Physical Findings

INDICATE PHYSICAL FINDINGS ON THE DIAGRAMS

Use these descriptions:

P - Pain

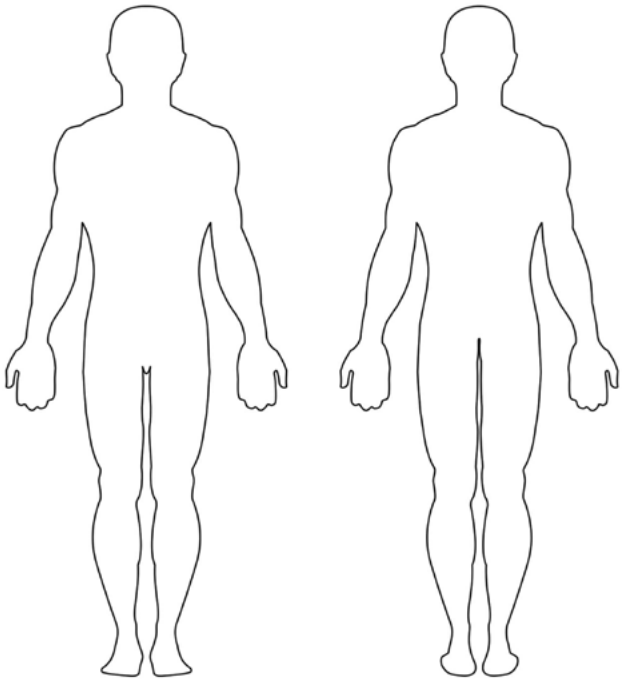
- Fracture

B - Burn

Lacn - Laceration

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

Otherwise, describe findings and include arrows

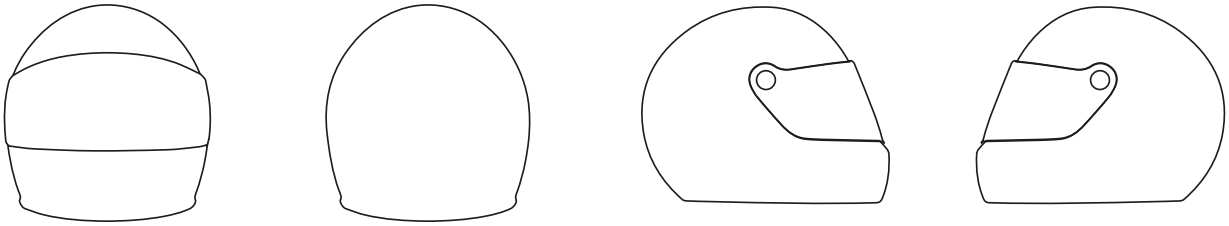


FRONT BACK

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					
Pulse	hrs	hrs	hrs	hrs	hrs	hrs
Respirations						
Blood Pressure						
CRT (Capillary Refill Time - in seconds)						
Colour						
Pain (0-10)						
Pupil Size (+/-)	R L	R L	R L	R L	R L	R L
GCS (Glascow 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

AIRWAY 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 SPECIFY)

CONDITION ON INITIAL PRESENTATION

WHAT (IF ANY) TREATMENT WAS PERFORMED

SUBSEQUENT TREATMENT RECOMMENDED

SUBSEQUENT TREATMENT RECOMMENDED ☐ URGENT ☐ NON URGENT

☐ HOME REST ☐ OWN DOCTOR ☐ HOSPITAL ☐ OTHER

Attending Doctor/Authorised Medical Personnel

NAME

SIGNATURE SIGN HERE

DATE ☐☐ – ☐☐ – ☐☐☐☐