1. Player name: ____________________________
2. Player SSID: ____________________________ 3. Team #: ____________________________
4. Today’s date (MM/DD/YY): ___________/_________/_________
5. Injury date (MM/DD/YY): ___________/_________/_________
6. Injury status:
   - New injury
   - Recurrence of injury from this hockey season
   - Recurrence of injury from previous hockey season
7. Did the player return to play the same game/practice?
   - No
   - OYes
   - Non-hockey injury (Go to 16)
If yes, how long did they continue to play for (minutes)? ________
8. At the time of injury, were any of the following worn?
   - Mouthguard: OUnknown ONo OYes
   - Mouthguard type: ODentist custom-fit OFree of charge OFree of charge (non-commercial)
   - Brace: OUnknown NO Yes: OLleft side ORright side
     If yes, worn on: OKnee OAnkle OWrist OOther: ________
   - Tape: OUnknown NO Yes: OLleft side ORright side
     If yes, worn on: OKnee OAnkle OWrist OOther: ________
9. Have you changed any equipment (since baseline?)
   - No
   - OYes
   - No baseline - entering study at injury
If yes, which? OMouthguard OHelmet OOther: ________
10. Position playing at time of injury:
    - OForward (Centre) OForward (Wing) ODifferent position (please specify)
    - OGoalie OOther: ________
11. Injury occurred during:
    - Game
      - Regular season  OTournament  OPlayoff  OEvaluation
      - Warm-up  OFirst period  OSecond period  OThird period
    - Practice on ice
    - Other (eg, dryland) Please specify: ________
12. This injury involved:
    - Sudden onset & contact with another player
    - OYes ONo
    - Gradual onset/Overuse (Go to 15) OUnknown (Go to 13)
13. Did you/the player anticipate the contact that resulted in injury?
   - OYes ONo
14. Cause of injury (check all that apply):
    - Body check: ODelivered OReceived
    - Other intentional player contact:
      - OElbowing ORoughing OHead contact OCross-checking
      - OTripping OSlashing OHigh Sticking
    - Unintentional contact with player or equipment
    - OContact with the environment, NOT another player
    - OPuck OBoards ONet OIce OOther: ________
15. Mechanism of injury (check all that apply):
    - ODirect blow to head: ORight OLeft OFront OBack OTop
    - OFell & hit head: ORight OLeft OForward OSide
    - OHit head: ONets ONnets ONice ONets ONet OOther: ________
    - ONeck & head injury
16. Was a penalty called directly related to the injury event?
   - OYes
   - If yes, OBody checking related OStick-related OHead-contact
   - OFighting OOther: ________
   - If yes, O2 min minor OSudden onset & contact with another player
   - ODouble minor O5 min major
   - OPenalty shot O10 min misconduct OMatch penalty
   - OGame misconduct OSuspension: length: ________
   - If yes, who received the penalty? (check all that apply)
     - OInjured player OInjured player’s teammate OOther team
17. Describe events surrounding injury:

18. Injury location for each type of injury (check all boxes that apply AND circle which site the injury occurred on):

19. Did any of the following visible signs occur:
    - Loss of consciousness
    - Slow to get up
    - Unsteady
    - Fall to ground
    - Clutch of head
    - Dazed
    - Blank look
    - Cut/bleeding on your face
18. Date of full medical clearance for return to: Normal daily activities (MM/DD/YY): _____/_____/_____

Non-contact sports (full participation) (MM/DD/YY): _____/_____/_____

Collision/contact sports (full participation) (MM/DD/YY): _____/_____/_____ 

Is the player returning to collision/contact sports? O No O Yes

19. Who provided clearance to return to play? O Physician O Therapist O Coach O Parent O Self O Other: _____________________

20. Total time parent/guardian missed work as a direct result of the player’s injury: ______ days + ______ hours O Not working

21. Parent/guardian’s occupation: _____________________ O Not working

22. Was an ambulance called? O No O Yes - If yes, did the player ride to the hospital in the ambulance? O No O Yes

23. Was the player admitted to the hospital (other than an emergency department visit)? O No O Yes

If yes, primary reason for hospitalization: _____________________ # nights in the hospital: ____________

If yes, did the player have surgery in the hospital? O No O Yes - Name or describe the surgery: _____________________

24. Did the player see any health care professional(s) for assessment/treatment of this injury? O No O Yes (check all that apply):

On-site first aid Total # visits: _____

EMT/Paramedic Total # visits: _____

Family Physician/GP Total # visits: _____

ER Physician Total # visits: _____

Sport Med. Physician Total # visits: _____

Paediatrician Total # visits: _____

Surgeon Total # visits: _____

Radiologist Total # visits: _____

Chiropractor Total # visits: _____

Physiotherapist Total # visits: _____

Athletic Therapist Total # visits: _____

Massage Therapist Total # visits: _____

Dentist Total # visits: _____

Other: ____________ Total # visits: _____

Paediatrician Total # visits: _____

Surgeon Total # visits: _____

Radiologist Total # visits: _____

Chiropractor Total # visits: _____

Physiotherapist Total # visits: _____

Athletic Therapist Total # visits: _____

Massage Therapist Total # visits: _____

Dentist Total # visits: _____

Other: ____________ Total # visits: _____

25. Did the player have any tests or receive any other treatment for this injury? O No O Yes

If yes, check all that apply:

MRI # of times: _____ Body part: ____________ 

X-ray # of times: _____ Body part: ____________ 

CT scan # of times: _____ Body part: ____________ 

Bone scan # of times: _____ Body part: ____________ 

Cast # of casts: _____ Body part: ____________ Type: ____________

Brace # of braces: _____ Body part: ____________ Type: ____________

Splint # of splints: _____ Body part: ____________ Type: ____________

Taping # of tape rolls: _____ Body part: ____________ Type: ____________

Crutches

26. Did the player take any medications for this injury? O No O Yes

If yes, name: ____________________________ type (eg, oral, injected):__________________________

duration (days): ____________ frequency (eg, # doses/day): ____________ dosage (eg, 200mg): ____________

If the player sees a physician, therapist, or other practitioner, have this healthcare provider complete the following section (unless a fee is involved). Upon completion, return to your Team Designate or study personnel.

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Medical practitioner’s name: ____________________________

Occupation: O Sport Med. Physician O Family Physician/GP O ER Physician

O Athletic Therapist O Physiotherapist

O Other: ____________________________

Date (MM/DD/YY): _____/_____/_____ 

Diagnosis/clinical impression (check both if needed):

O Concussion O Other: ____________________________

Treatment plan: O Rest until asymptomatic O Begin RTP steps O Return to full participation

O Other: ____________________________

Conditions of clearance: O Asymptomatic O Complete RTP steps

O Other: ____________________________

ONCE PLAYER IS CLEARED TO RETURN TO UNRESTRICTED COMPETITION:

Date of clearance (MM/DD/YY): _____/_____/_____ 

Appendix 4, as submitted by the authors. Appendix to: Eliason PH, Hagel BE, Palacios-Derflingher L. Bodychecking experience and rates of injury among ice hockey players aged 15–17 years. CMAJ 2022. doi: 10.1503/cmaj.211718. Copyright © 2022 The Author(s) or their employer(s). To receive this resource in an accessible format, please contact us at cmajgroup@cmaj.ca.