WAIS

ATHLETE MEDICAL REPORT FORM

Challenge Stadium | Stephenson Avenue | Mt Claremont WA 6010
P.O. Box 139 | Claremont WA 6910
TEL: (08) 9387 8166 | FAX: (08) 9383 7344
www.wais.org.au

When complete, please e-mail to wais@wais.org.au

Practitioner's Name:			**Contact Number:**	
Date:			**Date of Injury:**	
Athlete:			**Sport:**	
Type of Report:	**New Injury** ☐	**Follow Up** ☐	**Maintenance** ☐	**Medical** ☐
Region of Injury:				

Relevant Clinical History

Relevant Pre Existing Injuries:

Diagnosis

Follow up treatment required:

PHYSIOTHERAPY	**Name:**	**Date of appt:**
MEDICAL	**Name:**	**Date of appt:**
SPECIALIST	**Name:**	**Date of appt:**

Training Recommendations: Full ☐ **Modified** ☐ **No** ☐

Specify restrictions if modified:

Specific Rehabilitation:

Prognosis:

Expected Date to Return to Full Training:
Expected Date to Return to Competition:

Additional comments:

Next Appointment:

Athlete Consent ☐