

SEVERE INDOOR TRAMPOLINE PARK INJURY (SITPI) REQUIRING ADMISSION TO HOSPITAL Australian Paediatric Surveillance Unit Please contact the APSU (02) 9845 3005 or SCHN-APSU@health.nsw.gov.au if you have any questions about this form	APSU Office Use Only	
	Study ID #:	
<i>Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided.</i> DK=Don't Know; NA = Not Applicable. Please use your hospital EMR records to supplement your knowledge of the case		Version 2.8_22.10.2018

REPORTING CLINICIAN'S DETAILS:

1. APSU Dr Code/Name: / _____ 2. Date questionnaire completed: __ __ / __ __ / ____ ____ (dd/mm/yyyy)

PATIENT DETAILS:

3. First 2 letters of first name: 4. First 2 letters of surname: 5. Date of Birth: __ __ / __ __ / ____ ____ (dd/mm/yyyy)

6. Sex: Male Female Indeterminate 7. Postcode of family:

8. Child's ethnicity: Aboriginal Torres-Strait Islander Both Aboriginal and Torrest Strait Islander Caucasian
 East Asian South Asian (Indian Subcontinent) African Middle Eastern Pacific Islander
 Other (please specify): _____ Don't Know

9. Child's country of birth Australia Other (please specify): _____ Don't Know

10. Main language spoken at home: _____ Don't Know

If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to the APSU. Please keep the patient's name and other details in your records. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

The primary clinician caring for this child/young person is: **Name:** _____ **Hospital:** _____

MEDICAL HISTORY:

11. Date of admission to hospital: __ __ / __ __ / ____ ____ (dd/mm/yyyy)

12. Past medical history: Impaired hearing Impaired vision Development disorder Autism spectrum disorder
 ADHD Other disability (please specify): _____
 Other behavioural details: _____
 Other details: _____

13. a) Was this the child's first visit to an indoor trampoline park? Yes No Don't Know
 b) Has the child had any previous indoor trampoline park injury? Yes No Don't Know **If yes, please provide details of previous injury/ies:** _____

c) Does the child have a trampoline at home? Yes No Don't Know

14. Please provide date of the **current** injury: __ __ / __ __ / ____ ____ (dd/mm/yyyy)
If unsure please estimate time since injury – within the last: ____ days ____ weeks ____ months

15. Trampoline park/company: _____

16. Trampoline park location – town/suburb: _____ postcode:

17. Who was the child with at the park? Parent Guardian Other adult Friends Party
 Other (please specify): _____

18. Level of supervision at the trampoline park: Trampoline park staff (number if known _____) Parent
 Other carer (specify who): _____ None Other (please specify): _____

19. Activity at time of injury: (before completing this section you may find it helpful to view photographs of equipment and activities at trampoline parks in the study protocol document available at: <http://apsu.org.au/assets/new-studies/Severe-Indoor-Trampoline-Park-Injuries-Protocol-V1.4.pdf>)

- Walking on trampoline mat itself alone with others (please specify number of people): _____
- Jumping on trampoline alone with others (please specify number of people): _____
- Jumping between trampolines
- Attempting a trick or manoeuvre on the trampoline alone with others (please specify number of people): _____

- Basketball on a trampoline (please specify number of players): _____
- Dodgeball on a trampoline (please specify number of players): _____
- Bubble Soccer/Sumo Ball/Bubble Ball on a trampoline (please specify number of players): _____
- Using jumping wall
- Using balance beam
- Walking on concourse (area around the trampolines)
- Using Airmat/Airbag
- Dismounting trampoline: by jumping into foam pit (specify head first or feet first): _____
 somersault into a foam pit other dismount from trampoline into a foam pit (please specify): _____
- Dismounting a trampoline onto surrounding concourse
- Other dismount (please specify): _____
- Other activity (please specify): _____

20. Mechanism of injury (please tick all that apply):

Mechanism of Injury	Details
<input type="checkbox"/> Fall	<input type="checkbox"/> From trampoline (Please specify onto what surface? e.g. dismount area surrounding trampoline, foam pit, airmat): _____ <input type="checkbox"/> On trampoline <input type="checkbox"/> Through trampoline <input type="checkbox"/> Between trampolines <input type="checkbox"/> On concourse, not involving trampoline <input type="checkbox"/> From other apparatus (please specify): _____ <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Don't know
<input type="checkbox"/> Collision	<input type="checkbox"/> With other person/persons <input type="checkbox"/> With self (e.g. knee into face) <input type="checkbox"/> With object <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Don't know
<input type="checkbox"/> Entrapment	<input type="checkbox"/> Entrapment involving springs <input type="checkbox"/> Other entrapment (specify): _____ <input type="checkbox"/> Don't know
<input type="checkbox"/> Overexertion	(please specify): _____
<input type="checkbox"/> Other mechanism	(please specify): _____

21. First aid provided at the scene: Icepack Pain relief Splint None Other (please specify): _____
 Who provided first aid? _____

22. Method of transport to hospital (e.g. ambulance, private car): _____

DETAILS OF INJURIES:

23. Investigations in hospital: X-Ray CT scan Ultrasound MRI
 Other (please specify): _____

24. Were any blood tests requested? Yes No

FBC	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	(details if abnormal):
Lipase	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	(details if abnormal):
Liver Function Test	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	(details if abnormal):
Other (specify):	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	(details if abnormal):
Group and hold/cross-match	<input type="checkbox"/> Yes <input type="checkbox"/> No		

25. Injury Severity Score (ISS) if known: _____ Not calculated

26. Details of Injury (please tick all that apply)

<input type="checkbox"/> Head and neck	<input type="checkbox"/> Head external <input type="checkbox"/> Head intracranial <input type="checkbox"/> Face <input type="checkbox"/> Neck musculoskeletal	<input type="checkbox"/> Neck spinal <input type="checkbox"/> Dental <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Concussion	Details (e.g. C5 fracture, occipital laceration, parietal skull fracture, ligamentous injury, intracranial haemorrhage, maxillary fracture):
<input type="checkbox"/> Upper limb	<input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Elbow	<input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand and fingers	Details (e.g. left wrist distal radius compound fracture, laceration elbow, degloved finger):
<input type="checkbox"/> Lower limb	<input type="checkbox"/> Hip <input type="checkbox"/> Thigh/upper leg <input type="checkbox"/> Knee	<input type="checkbox"/> Leg below knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot and toes	Details (e.g. dislocated knee, fractured femur, sprained ankle):
<input type="checkbox"/> Torso	<input type="checkbox"/> Abdominal injury <input type="checkbox"/> Thoracic injury	<input type="checkbox"/> Back injury <input type="checkbox"/> Spinal injury	Details (e.g. Grade 2 liver laceration, T2 spinal injury, T4 spinous process fracture):
<input type="checkbox"/> Other Injury(ies)	(please specify details):		

TREATMENT IN HOSPITAL:

27. (a) General Admission - length of stay (days): _____
- (b) Intensive care admission - length of stay (days): _____
- (c) Blood Transfusion
- (d) Operation(s) - number of operations: _____ Please specify details (e.g. closed reduction, craniectomy): _____
- (e) Other acute treatment e.g. physiotherapy, rehabilitation (specify if patient transferred to inpatient rehabilitation unit or other type of rehabilitation): _____
- (f) Other treatment e.g. occupational therapy, psychology (please specify): _____

OUTCOME AT DISCHARGE:

28. Recommended time to resume pre-injury level of function and activities:

- (a) School/preschool Immediate Delayed (Time: _____) Not applicable
- (b) Sport Immediate Delayed (Time: _____) Not applicable
- (c) Self care appropriate for age Immediate Delayed (Time: _____) Not applicable
- (d) Work Immediate Delayed (Time: _____) Not applicable

29. List any functional limitations at discharge: _____

30. List any other health problems related to this injury (e.g. secondary complication, infection): _____

31. Follow up plans at discharge (please tick all that apply)

- Neurosurgery Orthopaedics General Surgeon Plastic Surgeon Rehabilitation Physiotherapy
- General Practitioner Dentist/maxillofacial None Other (details including ongoing therapy, or planned surgery that may be required): _____

32. Other relevant information/comments: _____

Thank you for your help with this research project.

Please return this questionnaire to the APSU via email to SCHN-APSU@health.nsw.gov.au or fax to 02 9845 3082

or mail to Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145 - even if you don't complete all items.

The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Sydney Medical School, The University of Sydney.

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This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.