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 #:*
Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided. 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**
☐ Fall	☐ From trampoline *(Please specify onto what surface? e.g. dismount area surrounding trampoline, foam pit, airmat)*: ____________________ ☐ On trampoline ☐ Through trampoline ☐ Between trampolines ☐ On concourse, not involving trampoline ☐ From other apparatus *(please specify):* ____________________ ☐ Other *(please specify):* ____________________ ☐ Don't know
☐ Collision	☐ With other person/persons ☐ With self *(e.g. knee into face)* ☐ With object ☐ Other *(specify):* ____________________ ☐ Don't know
☐ Entrapment	☐ Entrapment involving springs ☐ Other entrapment *(specify):* ____________________ ☐ Don't know
☐ Overexertion	*(please specify):* ____________________
☐ 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	☐ Normal	☐ Abnormal	*(details if abnormal):*
Lipase	☐ Normal	☐ Abnormal	*(details if abnormal):*
Liver Function Test	☐ Normal	☐ Abnormal	*(details if abnormal):*
Other *(specify):*	☐ Normal	☐ Abnormal	*(details if abnormal):*
Group and hold/cross-match		☐ Yes	☐ No

25. Injury Severity Score (ISS) *if known:* ____________________ ☐ Not calculated

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

☐ Head and neck	☐ Head external ☐ Head intracranial ☐ Face ☐ Neck musculoskeletal	☐ Neck spinal ☐ Dental ☐ Loss of consciousness ☐ Concussion	Details *(e.g. C5 fracture, occipital laceration, parietal skull fracture, ligamentious injury, intracranial haemorrhage, maxillary fracture):*
☐ Upper limb	☐ Shoulder ☐ Arm ☐ Elbow	☐ Forearm ☐ Wrist ☐ Hand and fingers	Details *(e.g. left wrist distal radius compound fracture, laceration elbow, degloved finger):*
☐ Lower limb	☐ Hip ☐ Thigh/upper leg ☐ Knee	☐ Leg below knee ☐ Ankle ☐ Foot and toes	Details *(e.g. dislocated knee, fractured femur, sprained ankle):*
☐ Torso	☐ Abdominal injury ☐ Thoracic injury	☐ Back injury ☐ Spinal injury	Details *(e.g. Grade 2 liver laceration, T2 spinal injury, T4 spinous process fracture):*
☐ 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.
The APSU is funded by the Australian Government Department of Health.
This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.