



CONCUSSION GUIDELINES 2025

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RECOGNISE

Defining concussion

Concussion is a type of brain injury that occurs due to a direct or indirect impact on the head, neck, or body, as well as direct forces or trauma to another body part, which results in a rapid movement of the head such as a whiplash injury. It is a severe condition that often leads to a sudden and temporary decline in brain functionality. Signs of concussion can appear instantly or gradually within a matter of minutes or hours. Although these symptoms usually resolve within a few days, there are instances where they persist for a longer duration.

Concussion can be diagnosed without the presence of loss of consciousness.

It is crucial to acknowledge the possibility of other head injuries accompanying a concussion, such as cuts, scrapes, or fractures on the scalp or face. Additionally, all head injuries should be treated as potentially connected to neck injuries until proven otherwise.

Diagnosing a concussion

Standard structural neuroimaging studies, such as CT or MRI, do not reveal any irregularities following a concussion since the main effect of a concussion is a disruption in brain function, manifested by a series of clinical symptoms, rather than a physical injury. However, in research environments, abnormalities may be detected in functional, blood flow, or metabolic imaging studies. Instead, concussions are typically identified using neuropsychological and cognitive assessments, in which scores are compared to a pre-established baseline test.

Who is most at risk for a concussion?

- Children and adolescents, aged 18 and under, are particularly vulnerable to the occurrence of concussions. Their recovery time is usually longer, and they are significantly affected in terms of memory and cognitive functions. They are also more prone to experiencing rare and perilous neurological complications, such as second impact syndrome, which can, in certain cases, be fatal due to swelling of the brain.
- Women, particularly in the same age range, are also identified as being highly susceptible to concussions.
- Individuals who have previously encountered a concussion are at greater risk of experiencing subsequent concussions.

The Consensus Statement

The Concussion in Sport Consensus Meeting regularly releases a position paper (Consensus Statement) that provides a summary of the latest evidence-based findings on concussion. This is the result of discussions among global authorities in the field. The most recent Consensus Statement, published in 2022 in Amsterdam, encompasses the current accepted guidelines for concussion management.

We have established concussion guidelines that align with the current Consensus Statement. These guidelines outline the expected level of care within the organisation and will be examined annually or when significant changes in knowledge occur. The guidelines acknowledge that scientific understanding of concussions is continually advancing, and the management and return to sport decisions will be made based on individual clinical judgement.

According to the Consensus Statement, it is recommended that children and adolescents refrain from participating in sports or any physical activity until they have fully recovered from their symptoms and returned to school without any signs of illness.

Our concussion guidelines align with FIBA guidance

Recognising concussion

Diagnosis of concussion is most accurately determined through clinical evaluation by a medical professional, which is considered the most reliable method. This evaluation is further backed by:

- A comprehensive examination of symptoms,
- Utilising established checklists like SCAT6 or Child SCAT6,
- Cognitive assessments, performed to evaluate memory functions, and other tests may also be employed to reinforce the accuracy of the diagnosis.

We support and promote:

“RECOGNISE and REMOVE”

The Amsterdam 2022 Concussion Consensus Group has created a highly useful resource called the Pocket Concussion Recognition Tool. This tool assists in identifying and promptly addressing concussions by emphasising the importance of early detection and removal. It offers a comprehensive list of indicators and symptoms that may suggest the occurrence of a concussion. By utilising this tool, individuals can effectively recognise and respond to concussions in a timely manner.

Visible signs and symptoms of concussion

Signs and symptoms of a concussion can occur at any point after the injury, but they usually become noticeable within the first 24-48 hours. During this period, it is important for the player to have company, get frequent check-ups, and receive a list of possible signs and symptoms. The person in charge of the player, such as a parent or guardian, should be given this checklist along with guidance on what steps to take if symptoms worsen. It is recommended that individuals with a concussion refrain from driving or drinking alcohol until they are completely free of symptoms.

The visible signs and reported symptoms of concussion include but are not limited to any one or more of the following:

Visible Signs of Concussion	Symptoms of Concussion
● Loss of consciousness or responsiveness ● Falling unprotected on the playing surface ● Lying motionless ● Disorientation or confusion, staring or limited responses, inability to respond to appropriate questions. ● Dazed, blank or vacant. ● Seizure fits or convulsions. ● Facial Injury ● Unsteady on feet or balance problems ● Slow to get up	● Headache ● “Pressure in head” ● Balance problems ● Nausea and vomiting ● Drowsiness ● Dizziness ● Blurred vision ● More sensitive to light ● More sensitive to noise ● Fatigue/Low energy ● “Don’t feel right” ● Neck Pain ● More emotional ● More irrational ● Sadness ● Nervous or anxious ● Difficulty concentrating ● Difficulty remembering ● Feeling slowed down ● Feeling “in a fog”

Questions to ask a player with a suspected concussion

1. Where are we today?
2. Who are we playing?
3. Which quarter are we in?
4. Which team did you play against last?
5. Who won that game?

Failure to answer any of these questions correctly may suggest a concussion. However, if all questions are answered correctly, it does not mean that a concussion can be ruled out.

If a player has signs or symptoms of a possible concussion that player must be:

“RECOGNISED AND REMOVED”
and
“IF IN DOUBT, SIT THEM OUT”

Players **MUST NOT** return to play or training on the same day of a suspected concussion.

REDUCE

Recommended training for staff

We recommend that all those with responsibility for courtside immediate care in the event of injury must maintain:

1. A valid, recognised immediate care in sport course; and
2. Complete the World Rugby Concussion Module for Healthcare professionals:
<https://passport.world.rugby/player-welfare-medical/concussion-management-for-doctors-and-health-care-professionals/>

It is recommended that concussion management implemented for all players diagnosed with a concussion or when a player is suspected of having a concussion during a game or training reflects this policy guidance. Those medical practitioners and approved healthcare professionals working within the organisation should strive for this management to include:

- Documentation of serial symptom analysis
- Assessment of cognitive function compared to a pre-injury baseline
- Documentation of general and neurological examination
- Documentation of balance assessment

A clinical judgement decision from the medical practitioner or designated approved healthcare practitioner will be the final decision about return to play.

REMOVE

What are the signs for immediate removal?

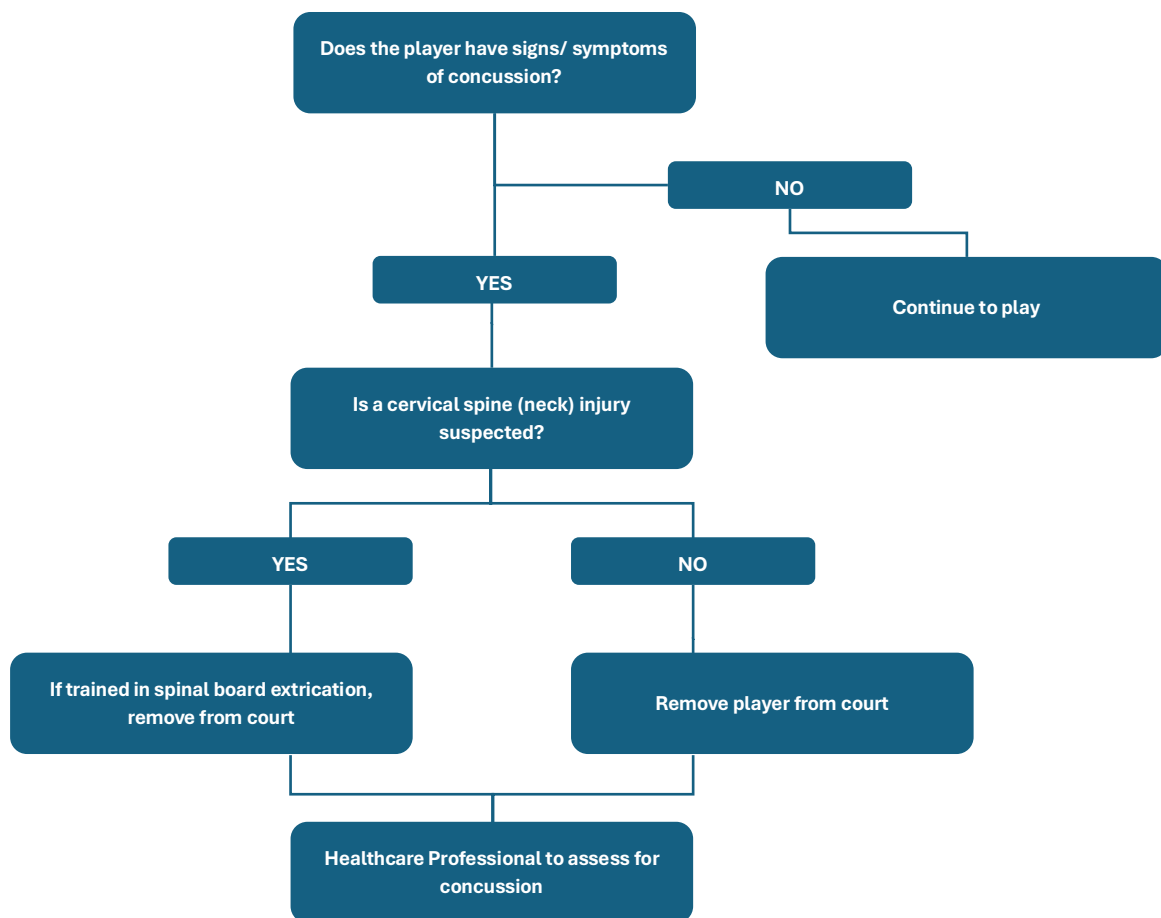
Red Flags - If any of the following red flag symptoms are reported or observed, then the player should be transported for an urgent medical assessment at the nearest hospital.

- Neck pain or tenderness
- Tonic posturing
- Balance disturbances / Ataxia
- Repeated vomiting
- Double vision, or loss of vision
- Seizures, fits or convulsions
- Severe or increasing headaches
- Weakness or tingling/burning in more than one arm or leg
- Confirmed or suspected loss or deteriorating consciousness
- Increasing confusion
- Increasing irritability, restlessness or combative
- Visible deformity of the skull

What should a player with suspected concussion not do?

- Do NOT drive a vehicle
- Do NOT drink alcohol
- Do NOT be left alone
- Do NOT be sent home alone

All players with a diagnosed concussion must be removed from play and not return to play or train on the same day.



Courtside – what to do?

It is recognised that there may be situations where a medical practitioner or approved healthcare professional is not present when injury occurs. Clubs and organisations are strongly encouraged to educate their staff including coaches on the signs and symptoms of concussions so that appropriate action can be taken at that time and medical support sought immediately.

The Pocket Recognition Tool can be used by all, and the newest tool CRT6 can be found here: [Pocket Concussion Recognition Tool](#)



The doctor or healthcare professional should wait **5 minutes** before assessing the player with suspected concussion to allow the athlete to recover from game induced fatigue and avoid false positives due to this fatigue. In this 5-minute period, it is recommended that they should view any video footage where possible to help determine the mechanism and severity of injury.

As basketball is a free interchange sport there are no time restrictions, so incorporating a period of rest is possible. Communication channels with coaching staff should be always maintained. If a concussion is suspected, a cautious approach must be adopted.

RE-EVALUATE

The assessment tools of a concussion (SCAT6 & SCOAT6).

The SCAT6 is a useful tool to aid the recognition and diagnosis of concussion. It is a standardised tool for evaluating injured athletes and can be used in athletes aged 13 years and older (see useful information and resources)

Note that there is a different SCAT6 document specifically for children aged 8 to 12 years, called the Child SCAT6.

Baseline Testing:

A baseline SCAT6 should be performed on all players as a priority following their selection to play. These baseline tests should be repeated every 2 years, in line with current guidance.

Testing Post Injury:

Following a suspected concussion, players will complete the SCAT6, and the results will be compared against their baseline. Variation in any element (symptom, cognitive assessment, balance evaluation) is strongly suggestive of concussion. The player should achieve the same, or better, result than their baseline test before returning to play.

If NO baseline data is available, then the following should be considered strongly as suggestive of a diagnosis of concussion

- Symptom checklist - one or more symptoms declared in the symptom list which are not usually experienced by the player following a match or training.

OR

- Balance evaluation: tandem stance with 3 or more errors or single leg stance test with 4 or more errors

OR

- If the results of the SCAT6 are as follows, a concussion is suspected:
 - Total standardised assessment of concussion (SAC) score 24 or below
 - Concentration score (digits backward) 2 or below
 - Delayed recall of 3 or fewer words

Neuropsychological testing

Concussion management tools 'ImPACT' and 'Cognigram' are the gold standard neuropsychological online testing tools, and it is recommended that players complete an online baseline test annually. A post-concussion test can then be completed, and results can be compared. This can be used in conjunction with symptom checklists, memory and balance evaluations as an aid to clinical decision making but should not be the sole determining factor in return to play.

RELATIVE REST

What is relative rest?

Rest means avoiding both **physical activity** (for example running, cycling, sport specific activities) and **cognitive / mental stimulation** (for example schoolwork, reading, television and computer games). Strict rest is no longer recommended, and instead the Amsterdam 2022 consensus recommends relative rest. This includes activities of daily living that do not exacerbate symptoms (including activities such as walking) and reduced screen time. The recommended relative rest period is **48 hours** starting from midnight on the day of the injury.



REHABILITATE, REFER AND RECOVERY

Ongoing management of concussion

Recovery from concussion should be considered on an **individual basis**. Most concussion injuries resolve over a 7-to-10-day period, although this can be longer in children and adolescents (under 18). The newest guidelines on returning to sport, suggests that no athlete should return to play quicker than 21 days unless they meet the specified criteria for the enhanced care pathway.

The importance of honesty

Players need to be encouraged not to ignore symptoms and to be honest with themselves, medical support staff and coaching staff. Players should not return to play until they are asymptomatic and have completed a full return to play protocol. It is recognised that there are heightened risks for younger players and extra caution should be taken to ensure they do not return to play or training if remaining symptomatic, this may require direct communication in writing to parents, schools and clubs.

The risks associated with early return to play include:

- a second concussion due to increased risk (second impact)
- an increased risk of other injuries because of poor decision making or reduced reaction time associated with a concussion
- reduced performance
- serious injury or death due to an unidentified structural brain injury
- a potential increased risk of developing long-term neurological deterioration

When to seek specialist help?

Players with any of the following should be assessed and managed by healthcare providers (multi-disciplinary) with experience in sports-related concussions:

- a second concussion within 12 months
- a history of multiple concussions
- unusual presentations of symptoms
- prolonged recovery and persisting symptoms (concussion symptoms that last longer than 4 weeks)
- concern that threshold for concussion symptoms is lowering

A specialist would be considered as a doctor on the GMC specialist register in Sport and Exercise Medicine, Neurology or Neurosurgery with a specialist interest, training and experience in treating concussions. If dizziness, neck pain or headaches persist longer than 10 days, cervico-vestibular rehabilitation is recommended, please discuss further with your club's healthcare professionals or a specialist doctor

RETURN-TO-SPORT

Standard Return to Sport (RTS) Protocol

The RTS contains six distinct stages: (both in the standard and enhanced care setting)

- **Stage 1:** A recommended relative rest period, with symptom limited activities of daily living.
- **Stage 2A:** Light aerobic exercise can begin keeping the max heart rate (HR) under approx. 55% (max HR calculated as 220 - athletes age).
- **Stage 2B:** Aerobic exercise can increase to a moderate level, keeping the max HR under approx. 70%.
Medical clearance is then recommended from a healthcare practitioner to progress to stage 3.
- **Stage 3:** Individual sport specific exercise can begin, including things such as light jogging, change of direction drills and shooting drills.
Athletes may only progress to stages 4-6 once they are symptom free and show no cognitive changes to baseline testing, including with and after physical activity. This must be confirmed with a healthcare practitioner.
- **Stage 4:** Non-contact training drills, high intensity, including things such as finishing drills, ball handling and 5 on 0.
Stages 1 - 4 must take a minimum of 14 days within the standard RTS.
- **Stage 5:** Full contact training as a normal training session would be, including 5 on 5, 1 on 1 and transitions.
The earliest that stage 6 can commence, and the athlete can return to sport is 21 days post injury.
- **Stage 6:** A final return to full training and competitive play stage.

Throughout the RTS the player can proceed to the next stage if they have no more than brief and mild exacerbation of symptoms of concussion (from the SCAT6 list) and after a minimum of 24 hours. However, stages 1 - 4 must take a minimum of 14 days and the player must not return to sport (stage 6) until at least 21 days post injury.

A brief and mild exacerbation of symptoms is classed as no more than an increase in 2 points on a 0-10 scale for less than an hour compared to their baseline score.

If any symptoms occur while progressing through stages 1-3 of the RTS protocol, the player must wait a day before then trying the exercise again the next day. Athletes experiencing concussion related symptoms in stages 4-6 should return to stage 3 until they become symptom free again.

It is strongly recommended that a medical practitioner or approved healthcare practitioner manage the RTS. However, when this is not possible the RTS should be observed and managed by someone familiar with the player who could identify any abnormal signs/behaviours displayed by the player. It is therefore the responsibility of clubs, officials, staff, players and parents to read this policy and other associated literature to raise awareness of the condition, be able to recognize the signs and symptoms and take appropriate action. Clearance to play in competition by a medical practitioner should always be sought.

The return to play times that are set out in the following RTS protocols are the minimum times required. Not all players will respond within these time frames; therefore, it is essential to treat each case individually.

In the event of a player not recovering, worsening or suffering a recurrence of symptoms, specialist medical advice must be sought immediately (see 'When to seek a specialist's help?' section).

RETURN TO SPORT PROTOCOL FOR PLAYERS

	Stage 1 - Symptom Limited Activity	Stage 2A – Light aerobic exercise	Stage 2B - Moderate aerobic exercise	Stage 3 - Individual sport specific exercise*	Stage 4 - Non contact training drills**	Stage 5 - Full contact training	Stage 6 - Return to Sport
<i>Duration</i>	48 hours	Minimum 24 hours	Minimum 24 hours	Minimum 24 hours	Minimum 24 hours	Minimum 24 hours	Minimum 24 hours
	Stages 1 - 4 must take a minimum of 14 days.					<i>This must only begin after 14 days of being symptom free.</i>	<i>Earliest return to play at 21 days post concussion.</i>
<i>Exercises Allowed</i>	Relative rest for the first 48 hours gradually reintroducing activities of daily living that do not exacerbate symptoms (e.g. walking).	Stationary cycling or walking at a slow to medium pace. Light resistance training can start if it does not exacerbate symptoms***	Stationary cycling or walking at a slow to medium pace. Light resistance training can start if it does not exacerbate symptoms (no more than an increase of 2 points on a 0-10 scale).	Light jogging, 20 lengths of the court (including some change of direction) or 10 minutes on the treadmill. Shooting drills such as spot shooting and cone shooting. No activities involving any head impact.	High intensity, more challenging training drills including finishing drills, ball handling and 5 on 0.	Normal training sessions, full contact training drills including 5 on 5, 1 on 1 and transitions.	Competitive match, no restrictions.
<i>% Max Heart Rate</i>	Not applicable as no training	 <55%	 <70%	 <90%	No limit	No limit	No limit
<i>Session Duration (minutes)</i>	Not applicable as no training	 <15	 <45	 <60	No limit	No limit	No limit
<i>Objective</i>	Reintroduction to school/work	Increase heart rate	Increase heart rate	Add movement and change of direction.	Return to normal intensity of exercise, coordination and increased thinking.	Restore confidence and assess functional skills.	Return to play

Review and clearance required from Team Doctor or HCP

* Medical clearance **recommended** by a HCP (prior to Stage 3)

** Medical clearance **required** by a HCP (prior to Stage 4)

*** Mild and brief exacerbating symptoms are classed as no more than 2 points of increased symptoms (on a scale of 0-10) for no longer than 1 hour when compared with their baseline score.

Enhanced Care Settings (Minimum 12 days)

In certain, exceptional circumstances, this protocol can be enhanced, to allow for a quicker return to sport. There are specific minimum criteria that must be met in order to do so. Within the organisation, this is likely to apply only to some professional teams and national teams due to the criteria that needs to be met.

Enhanced Care Pathway (Minimum 12 days)

The specific minimum criteria are:

- There must be a doctor on the GMC register with appropriate indemnity, training and experience in treating concussions who will take responsibility and oversee the care in person or remotely as appropriate to the clinical situation.
- The player must have a baseline SCAT6 and neurocognitive baseline computer testing (either ImPACT or Cognigram) from prior to the injury.
- There must be ongoing serial clinical assessments (including regular SCAT6 testing) to include symptom review, cognitive function and neurological function which is formally documented in the players medical notes and is maintained throughout the RTS protocol.
- The player must have access to a comprehensive multidisciplinary team with experience in managing sport concussion injuries to include sports medicine doctors/neurologists/neurosurgeons to oversee further interventions as required.
- A formal RTS protocol should be established and implemented, in which regular SCAT6/SCAT6 or similar assessments are conducted and documented in the players' medical records.
- The team can demonstrate provision of education to all staff and players around concussion injuries.
- The player must be over 18 years of age.

It is an absolute **requirement** that the whole RTS protocol in an enhanced care setting must be supervised by a doctor within a structured concussion management programme.

The time frames displayed below within the enhanced care setting are the minimum required and players who take longer to recover will need increased timeframes to successfully negotiate the return to play. The enhanced care protocol begins at midnight on the day of injury.

Enhanced Care Pathway – Minimum 12 days

	Stage 1 - symptom limited activity	Stage 2A - light aerobic exercise	Stage 2B - moderate aerobic exercise	Stage 3 - individual sport specific exercise	Stage 4 - noncontact training drills	Stage 5 - full contact training	Stage 6 - return to sport
<i>Standard duration*</i>	48 hours	Day 3 & 4		Day 5 & 6	Day 7 & 8	Day 9, 10 & 11	Day 12 earliest RTS
<i>Exercises allowed</i>	Relative rest for the first 48 hours gradually reintroducing activities of daily living that do not exacerbate symptoms	Stationary cycling or walking at a slow to medium pace. Light resistance training can start if it does not exacerbate symptoms.	Stationary cycling or walking at a slow to medium pace. Light resistance training can start if it does not exacerbate symptoms (no more of an increase of 2 points on a 0-10 scale).	Light jogging, 20 lengths of the court (including some change of direction) or 10 minutes on the treadmill. Shooting drills such as spot shooting or cone shooting. No activities involving any head impact.	High intensity, more challenging training drills including finishing drills, ball handling and 5 on 0.	Normal training sessions, full contact training drills including 5 on 5, 1 on 1 and transitions.	Competitive match, no restrictions.
<i>% Max Heart Rate</i>	Not applicable as no training	<55%	<70%	<90%	No limit	No limit	No limit
<i>Session duration (minutes)</i>	Not applicable as no training	<15	<45	<60	No limit	No limit	No limit
<i>Objective</i>	Reintroduction to school/work	Increase heart rate	Increase heart rate	Add movement and change of direction	Return to normal intensity of exercise, coordination and increased thinking.	Restore confidence and assess functional skills.	Return to play.

Early Return to Play within the Exceptional Care Pathway (Minimum 7 days)

In certain circumstances, an adult player may be eligible for an expedited return to play under the enhanced care protocol, however they must meet the following criteria:

- The player must be over 18 years of age.
- They must have **no history** of significant, complex or recurrent concussions, classified by:
 1. A previous concussion within the last 12 months
 2. 5+ concussion within their sporting career
 3. Previous concussion with complicated psychological symptoms
 4. A previous concussion that took longer than 21 days to recover
- There must be **no evidence** of the following red flags during or immediately after the injury:
 - Traumatic convulsion (seizures or fits)
 - Tonic posturing (sudden tension or stiffness in the body)
 - Confirmed loss of consciousness
 - Suspected loss of consciousness
 - Ataxia - unsteady on feet
 - Disoriented or confused
 - Behavioural changes
 - Oculomotor signs
- A **normal SCAT6** must be recorded at 36-48 hours post injury
- A healthcare practitioner must be available to review the players symptoms and progressions daily
- The player will need to be signed off by a doctor who is registered with the GMC.

Early Return to Play within the Exceptional Care Pathway (Minimum 7 days)

	Stage 1 - symptom limited activity	Stage 2A - light aerobic exercise	Stage 2B - moderate aerobic exercise	Stage 3 - individual sport specific exercise	Stage 4 - noncontact training drills	Stage 5 - full contact training	Stage 6 - return to sport
<i>Early RTS (if exceptional criteria are met)*</i>	48 hours	Minimum 24 hours		Minimum 24 hours	Minimum 24 hours	Minimum 24 hours	Day 7 RTS permitted only if exceptional criteria is met.
<i>Exercises allowed</i>	Relative rest for the first 48 hours gradually reintroducing activities of daily living that do not exacerbate symptoms	Stationary cycling or walking at a slow to medium pace. Light resistance training can start if it does not exacerbate symptoms.	Stationary cycling or walking at a slow to medium pace. Light resistance training can start if it does not exacerbate symptoms (no more of an increase of 2 points on a 0-10 scale).	Light jogging, 20 lengths of the court (including some change of direction) or 10 minutes on the treadmill. Shooting drills such as spot shooting or cone shooting. No activities involving any head impact.	High intensity, more challenging training drills including finishing drills, ball handling and 5 on 0.	Normal training sessions, full contact training drills including 5 on 5, 1 on 1 and transitions.	Competitive match, no restrictions.
<i>% Max Heart Rate</i>	Not applicable as no training	<55%	<70%	<90%	No limit	No limit	No limit
<i>Session duration (minutes)</i>	Not applicable as no training	<15	<45	<60	No limit	No limit	No limit
<i>Objective</i>	Reintroduction to school/work	Increase heart rate	Increase heart rate	Add movement and change of direction	Return to normal intensity of exercise, coordination and increased thinking.	Restore confidence and assess functional skills.	Return to play

RECONSIDER AND RETIRE

The potential long-term effects of concussion

There are increasing concerns about potential issues with brain health in athletes who have experienced concussion once they have retired, such as mental health problems, difficulties with thinking and memory, and diseases related to the nervous system.

It is crucial to understand the potential higher risks involved and to carefully consider retiring or stopping contact or collision sports. These decisions are complicated and it's important to involve experts in traumatic brain injury and sports into the decision making, preferably a team of various specialists. The decision-making process should include a thorough evaluation that considers factors such as the patient's condition, the nature of the injury, the specific sport, and other sociocultural factors.

As exercise has many positive effects on health, it is important to make sure that all physical activity is not completely restricted. Athletes who retire from contact or collision sports should be encouraged to engage in non-contact or low-contact physical activities to continue experiencing the health benefits of exercise.

REFINE

As the field of concussion research evolves, we will continue to embrace ongoing strategies to advance our understanding.

USEFUL INFORMATION AND RESOURCES

- SCAT6 (ages 13+): [Sport Concussion Assessment Tool 6 \(SCAT6\)](#)
- SCOAT 6: [Sport Concussion Office Assessment Tool 6 \(SCOAT6\)](#)
- Children's SCAT6 (ages 8-12): <https://passport.world.rugby/media/xtiffq5b/child-scat6.pdf>
- Video Abstract for 2022 Concussion Consensus Summary: <https://bjsm.bmj.com/content/57/11/695#F3>
- Concussion Pocket Recognition Tool 6 (2022): <https://passport.world.rugby/media/nlnhp1es/the-concussion-recognition-tool-6.pdf>
- Amsterdam 2022 Concussion Group Consensus Statement: <https://bjsm.bmj.com/content/bjsports/57/11/695.full.pdf>
- Berlin 2016 Concussion Group Consensus Statement: <https://bjsm.bmj.com/content/51/11/838>

REFERENCES

Patricios JS, Schneider KJ, Dvorak J, et al. (2023). Consensus statement on concussion in sport: the 6th International Conference on Concussion in Sport–Amsterdam, October 2022. *British Journal of Sports Medicine* 57, 695-711.

Putukian M, Raftery M, Guskiewicz K, et al. (2013). On field assessment of concussion in the adult athlete. *British Journal of Sports Medicine* 47, 285–288.

Other sports concussion policies:

- [If in doubt, sit them out](#)
- [Play | Rugby Football Union](#)
- [Scottish sports concussion guidance - sportscotland the national agency for sport in Scotland](#)

Title	Concussion Guidelines
Policy No	4.4
Author	Dr Dane Vishnubala, Andy Howse, Tom Cresswell, Dr Peter Thain, Dr Amir Pakravan
Responsible Person	Dr Dane Vishnubala
Authorised	
Issue Date	April 2025
Review Date	Every two years unless review is required earlier
Policy No and Version	Version 01
References	Patricios JS, Schneider KJ, Dvorak J, et al. (2023). Consensus statement on concussion in sport: the 6th International Conference on Concussion in Sport–Amsterdam, October 2022. <i>British Journal of Sports Medicine</i> 57, 695-711.
Appendix	
Scope	All individuals in the employ of this establishment <i>(‘employ’ means any person who is employed, self-employed, volunteers, working under practising privileges or contract of service with this establishment)</i>