

Medical Diagnostics Form for athletes with physical impairment

The form must be completed in English by a registered medical doctor (M.D.) with a specialization of the Athlete's Health Condition.

The completed form with attached medical documentation must be uploaded to the athlete's SDMS profile upon registration of the athlete to the SDMS. This applies for all athletes with physical impairment competing in Para Athletics. Depending on the athlete's health condition and impairment, additional medical information is to be attached to this form (see page 2).

Note

The measurement of impairment seen during athlete evaluation must correspond to the diagnosis indicated below. If the medical documentation is incomplete, Para Athletics holds the right to request further information. In absence of such information, the athlete will not be able to proceed with Athlete Evaluation.

Athlete Information

(to be prepopulated by the NPC/National Federation)

Family name:			
Given name:			
Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	Date of Birth: (dd/mm/yyyy)
Country:		SDMS ID:	
<input type="checkbox"/> The athlete's Sport Class Status is New <input type="checkbox"/> The athlete's Sport Class Status is Review			

Medical Information

Note: The list of medical diagnosis shows examples and is not exhaustive.

Eligible Impairment (tick)	Name medical diagnosis relevant to impairment type (tick or add)	Documents to support the diagnosis (tick or add)
<input type="checkbox"/> Impaired muscle power	<input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Polio Myelitis <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> ASIA scale <input type="checkbox"/> Electromyography <input type="checkbox"/> MRI <input type="checkbox"/> X-rays <input type="checkbox"/> Biopsy <input type="checkbox"/> Other _____
<input type="checkbox"/> Impaired passive range of motion	<input type="checkbox"/> Arthrogryposis <input type="checkbox"/> Joint Contractures <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Goniometric measures of joint limitations
<input type="checkbox"/> Ataxia <input type="checkbox"/> Athetosis <input type="checkbox"/> Hypertonia	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> Modified Ashworth Scale <input type="checkbox"/> Cerebral MRI or TC scan <input type="checkbox"/> Other _____
<input type="checkbox"/> Leg length difference	<input type="checkbox"/> Trauma <input type="checkbox"/> Dysmelia <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> X-rays <input type="checkbox"/> Photograph <input type="checkbox"/> Other _____
<input type="checkbox"/> Short stature	<input type="checkbox"/> Achondroplasia <input type="checkbox"/> Osteogenesis Imperfecta <input type="checkbox"/> Growth Hormone Dysfunction <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> X-rays <input type="checkbox"/> Photograph <input type="checkbox"/> Other _____
<input type="checkbox"/> Limb deficiency	<input type="checkbox"/> Dysmelia <input type="checkbox"/> Traumatic Amputation <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Other _____

Medical history:

Athlete's condition is:	<input type="checkbox"/> Stable	<input type="checkbox"/> Progressive	<input type="checkbox"/> Fluctuating	<input type="checkbox"/> Permanent
Age of onset:	(yyyy)		<input type="checkbox"/> Congenital	
Past treatments:				
Current treatments:				
Anticipated future treatments:				

Additional details on medical diagnosis (if needed):

Medications and reason for prescription:

I confirm that the above information is accurate.

Name:

Medical Specialty:

Registration Number:

Address:

City:

Country:

Phone:

E-mail:

Date:

Signature: