Medical Diagnostics Form

The form is to be completed in English by the athlete's individual physician.

Depending on the athlete's health condition and impairment, additional medical information is to be attached to this form (see page 2).

The form has to be sent to classification@powerchairhockey.org no later than six (6) weeks before the athlete undergoes the evaluation.

Athlete Information

Last Name: Text ________________________________

First Name: ________________________________

Gender: ❑ Female ❑ Male Date of Birth: ________________

Sport: **POWERCHAIR HOCKEY**

Years/months competing in the sport at national level:________________________________

Medical Information

Description of the Athlete's medical diagnosis and the loss of function this health condition results in:

Health condition is: ❑ progressive ❑ stable

Medical history:

Health condition is: ❑ acquired ❑ congenital

If acquired, age of onset: ________________________________

Anticipated future procedure(s): ________________________________

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Medications:

Attachments

The athlete's health condition as stated on this form and the resulting impairment must fully explain the loss of function exhibited by the athlete during athlete evaluation. Otherwise no sport class can be allocated by the classification panel, as stipulated in the IPC Sport's classification rules.

Therefore, additional, recent and relevant medical documentation has to be attached to this form if the athlete has

- an impairment or diagnosis that cannot be ascertained by clear signs and symptoms;
- a complex or rare health condition, or multiple impairments;
- a spinal cord injury (recent ASIA scale results to be enclosed);
- one of the coordination related impairments ataxia, athetosis or hypertonia (Modified Ashworth Scale scores to be enclosed).

Reports on additional testing by physicians, physiotherapists and other health professionals are welcomed, where relevant, to complement the medical diagnostic information.

The IPCH Sport and the Classification Panel may ask for further information to be submitted depending on the individual athlete's health condition and impairment.

❑ I confirm that the above information is accurate

Name: ____

Health care profession: ____

Registration Authority and Number: ____

Address: ____

City: ______________________ Country: ______________________

Phone: ______________________ Email: ______________________

Date: ______________________ Signature: ______________________