*ATHLETE NUMBER-OFFICE USE ONLY*

OMB Number: 2900-0759
Expiration Date: Xxx, 20XX
Respondent Burden: 10 minutes

Department of Veterans Affairs

# GENERAL MEDICAL FORM

***TO BE COMPLETED BY PARTICIPANT. PLEASE TYPE OR PRINT CLEARLY.***

**PRIVACY ACT:** VA is asking you to provide the information on this form under USC, Chapter 5, Section 521 and Chapter 17, Section 1710. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 121VA19 "National Patient Databases - VA". Providing the requested information is voluntary. However, you will not be able to participate in the event without furnishing this information.

**RESPONDENT BURDEN:** The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 10 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

| DATE | | VA MEDICAL CENTER NAME |
|---|---|---|
| NAME *(Last, First, MI)* | | ADDRESS *(Street, City, State, Zip Code)* |
| E-MAIL ADDRESS | | |
| SOCIAL SECURITY NO. *(Last 4 digits only)* | DATE OF BIRTH | TELEPHONE NUMBER *(Include area code)* |

| TEAM COORDINATOR/LEADER: | TELEPHONE NUMBER | E-MAIL ADDRESS |
|---|---|---|
| **In Case of Emergency, Notify *(Name)*:** | TELEPHONE NUMBER | RELATIONSHIP TO PATIENT |

***TO BE COMPLETED BY THE EXAMINING PHYSICIAN. PLEASE TYPE OR PRINT CLEARLY.***

***Dear Doctor:*** *Your detailed exam of the participant will be very helpful to the medical assistance team. If an assistant completes the form, please countersign the exam.*

**DIAGNOSIS/TYPE OF INJURY**

DATE OF INJURY OR DIAGNOSIS _____

☐ SPINAL CORD INJURY (SCI)--LEVEL OF INJURY: _____ AIS: _____

☐ PARAPLEGIC ☐ QUADRAPLEGIC

☐ MULTIPLE SCLEROSIS (MS)

☐ AMPUTEE

☐ HEAD INJURY

☐ OTHER *(Please specify)* _____

**VA IDENTIFICATION CARD**

**PLEASE ATTACH A COPY OF VA IDENTIFICATION CARD HERE**
***(See below)***

If you do not attach a copy of your VA IDENTIFICATION CARD you **must** fill out VA Form 10-10EZ including your full Social Security Number.

**MEDICATIONS** *(List relevant medications only. Please do NOT submit VA medications list)*

If accepted to participate in the NVWG and your medical condition changes between now and the NVWG, it is your responsibility to check with your physician and modify your events as appropriate. The NVWG is a sports competition that requires physical exertion. For the best outcomes and your safety, you should be training to participate in your particular events. Please consult your physician or therapist for recommendations and assistance.

# PHYSICAL FORM

| WEIGHT | HEIGHT | LUNGS | HEART | SKIN |
|---|---|---|---|---|
| | | | | |

OTHER FINDINGS

**PRESENT AND PAST MEDICAL HISTORY AND MAJOR OPERATIONS** ***(Diabetes, heart disease, hypertension, etc.)***

IS THE PATIENT ON DIALYSIS?* *(Patient is responsible for setting up any dialysis treatment needed)* ☐ YES ☐ NO

IS THE PATIENT ON A VENTILATOR? ☐ YES ☐ NO

IS THE PATIENT ON ANTICOAGULANT DRUGS? *(If yes, which)* ☐ YES ☐ NO _____

**PHYSICIAN CLEARANCE**

In my opinion, the above individual is cleared to participate in the events they have indicated on their NVWG registration.

**PHYSICIAN INFORMATION**

☐ VA ☐ NON-VA

NAME OF EXAMINING PROVIDER *(Please print) (Check appropriate box)*

☐ MD ☐ PA ☐ NP

ADDRESS *(Street, City, State and Zip Code)*

SIGNATURE OF EXAMINING PROVIDER

TELEPHONE NUMBER DATE

**NVWG AND/OR USQRA CLASSIFICATION CARD(S)**

**PLEASE ATTACH A COPY OF YOUR CLASSIFICATION CARD(S)**
***(See below)***

If applicable, please attach a **copy** (not the original) of you National Veterans Wheelchair Games, USQRA (quad rugby), and/or Wheelchair Sports, USA classification card above.

May omit only if copy of current NVWG Classification card is provided.

*This section must be completed by someone familiar with direct muscle testing, i.e., a physician, physical therapist, kinesiotherapist, or occupational therapist.*

## NEURO EXAM *(Manual muscle test, 0-5)*

| UPPER EXTREMITY | RIGHT | LEFT |
|---|---|---|
| DELTOID | | |
| BICEPS | | |
| WRIST EXTENSION | | |
| WRIST FLEXION | | |
| TRICEPS | | |
| FINGER EXTENSION | | |
| FINGER FLEXION | | |
| FINGER ABD/ADD | | |

| LOWER EXTREMITY | RIGHT | LEFT |
|---|---|---|
| HIP FLEXION | | |
| HIP EXTENSION | | |
| HIP ADDUCTION | | |
| HIP ABDUCTION | | |
| KNEE FLEXION | | |
| KNEE EXTENSION | | |
| DORSIFLEXION | | |
| PLANTARFLEXION | | |

**SITTING BALANCE** *(Please check one)*

☐ NORMAL ☐ FAIR

☐ POOR ☐ NONE

**HANDEDNESS** *(Please check one)*

☐ RIGHT ☐ LEFT

| TRUNK *(0-5 scale)* | UPPER | LOWER |
|---|---|---|
| ABDOMINALS | | |
| SPINAL EXTENSORS | | |