OMB Number:
Respondent Burden: 20 minutes

Department of Veterans Affairs

GENERAL MEDICAL/PHYSICAL EXAM FORM

NATIONAL DISABLED VETERANS WINTER SPORTS CLINIC

(To be completed by Examining Clinician)

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 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

Dear Clinician: Please fill out completely the two medical pages. In addition, please include (1) a copy of a recent EKG for anyone 40 years of age and older, (2) a recent H&P/Problem list and (3) a list of current medications and dosages. **PLEASE TYPE OR PRINT CLEARLY**

PATIENT'S NAME	SOCIAL SECURITY NUMBER *(Last 4 digits only)*	DATE	AGE

PATIENT'S DAYTIME PHONE NUMBER *(Include area code)*	EVENING PHONE NUMBER	VAMC WHERE PATIENT RECEIVES CARE

PRIMARY DISABILITY/DIAGNOSIS

- ☐ SPINAL CORD INJURY (SCI) - LEVEL _____ ☐ COMPLETE ☐ INCOMPLETE
- ☐ PARAPLEGIC ☐ QUADRIPLEGIC
- ☐ MULTIPLE SCLEROSIS (MS)
- ☐ HEAD INJURY
- ☐ CVA WITH RESIDUAL
- ☐ AMPUTEE ☐ RIGHT LEG, A/K, B/K ☐ RIGHT ARM, A/E, B/E ☐ OTHER _____
  ☐ LEFT LEG, A/K, B/K ☐ LEFT ARM, A/E, B/E

VISUAL IMPAIRMENT DIAGNOSIS ***(For Visually Impaired patient's ONLY)***

IS THE PATIENT LEGALLY BLIND?

☐ YES ☐ NO ☐ VISUAL ACUITY (<20/200 OU) ☐ VISUAL FIELD LOSS (<20 DEGREES OU) ☐ TOTALLY BLIND

DESCRIPTION OF REMAINING VISION?

_____

PLEASE RATE YOUR PATIENTS LEVEL OF INDEPENDENCE

- ☐ INDEPENDENT WITH SELF CARE NEEDS, INDEPENDENT ONCE ORIENTED
- ☐ INDEPENDENT WITH SELF CARE NEEDS, NEED SIGHTED GUIDE OCCASIONALLY AFTER ORIENTATION
- ☐ INDEPENDENT WITH SELF CARE NEEDS, NEED SIGHTED GUIDE CONTINUOUSLY
- ☐ NEED SOME ASSISTANCE WITH SELF CARE, NEED SIGHTED GUIDE

PATIENT NEEDS

PATIENT REQUIRES ATTENDANT?	☐ YES	☐ NO	IF YES, ATTENDANTS' NAME _____
USES WHEELCHAIR MAJORITY OF TIME?	☐ YES	☐ NO	
WILL THIS PATIENT NEED TO SKI SITTING DOWN?	☐ YES	☐ NO	
USES OTHER ADAPTIVE EQUIPMENT?	☐ YES	☐ NO	IF YES, WHAT _____

SITTING BALANCE

☐ NORMAL ☐ FAIR ☐ POOR

PATIENT'S NAME	SOCIAL SECURITY NUMBER *(Last 4 digits only)*

MEDICAL HISTORY - DO NOT SEND IN WITHOUT ALL OF THE FOLLOWING

1. Attach your H & P (history and physical) problem list with all medical and surgical history.
2. Attach recent EKG for any patient **40 years of age and older.**
3. Attach list of current medications.
4. Attach discharge summary for any patient hospitalized during the last three (3) years.

ALLERGIES

DOES THE PATIENT HAVE A HISTORY OF ALTITUDE SICKNESS? ☐ YES ☐ NO IF YES, EXPLAIN _____

DOES THE PATIENT HAVE DYSREFLEXIA? ☐ YES ☐ NO IF YES, EXPLAIN _____

DOES THE PATIENT HAVE ANTICOAGULATION OR OXYGEN REQUIREMENTS? ☐ YES ☐ NO IF YES, EXPLAIN _____

DOES THE PATIENT SMOKE? ☐ YES ☐ NO

ALCOHOL OR SUBSTANCE ABUSE? ☐ YES ☐ NO IF YES, DESCRIBE _____

CARDIOPULMONARY REVIEW OF SYSTEMS WAS DONE AND IS UNREMARKABLE ☐ YES

PHYSICAL EXAM *(To be filled out completely by physician)*

HEIGHT _____ *(inches)* WEIGHT _____ *(pounds)*

Weight limit for anyone who needs to ski sitting down is 220 pounds; weight limit for stand up skiers is 300 pounds.
Please DO NOT clear anyone over the weight limits.

PULSE _____ BLOOD PRESSURE _____

HEENT _____ CARDIAC _____

PULMONARY _____ ABDOMEN _____

EXTREMITIES _____ NEURO _____

Dear Clinician: Your patient is planning on participating in a **vigorous** outdoor winter sporting event that takes place at **high altitude**. Examples of high-risk patients are: a quadriplegic smoker who is overweight; brittle diabetics; patients with significant COPD or CHF; and patients that require close medical supervision. Patients are admitted to this clinic based on your judgements about their current health status.

PLEASE DO NOT APPROVE ANY PATIENT THAT HAS RISK OF DEVELOPING MEDICAL COMPLICATIONS BY PERFORMING STRENUOUS EXERCISE AT ALTITUDES >10,000 FEET OR HAS THE POTENTIAL TO REQUIRE HOSPITATILIZATION DUE TO A PRE-EXISTING CONDITION. IF THEY REQUIRE HOSPITALIZATION FOR A PRE-EXISTING CONDITION, YOUR MEDICAL CENTER WILL BE LIABLE FOR ANY CHARGES INCURRED OUTSIDE OF VA CARE. DO NOT SEND ANY PATIENT THAT IS CURRENTLY UNSTABLE OR UNDERGOING CARIOPULMONARY EVALUATION FOR CLINICAL INSTABILITY.

If the patient's condition changes before the event, please contact Dr. John Hunter at the Grand Junction VAMC, (970) 242-0731-page through operator or contact Department of Medicine, ext. 4247, e-mail John.Hunter@va.gov.

☐ PATIENT **IS** MEDICALLY FIT TO PARTICIPATE ☐ PATIENT **IS NOT** MEDICALLY FIT TO PARTICIPATE

SIGNATURE AND TITLE OF EXAMING CLINICIAN	NAME OF EXAMING CLINICIAN *(Please print)*
HOSPITAL AND ADDRESS OF EXAMINING CLINICIAN	TELEPHONE NUMBER