ANNEX 2 – Medical Diagnosis Form (MDF)

This form must be completed in English by a registered medical doctor (M.D.) with a specialization in the Athlete's Health Condition (Article 8.5.2.1 of the Classification Rules)

The completed form with attached medical documentation must be sent to the Eligibility Assessment Committee, or a hard copy must be presented to Chief Classifier before the start of Athlete Evaluation. Athlete Evaluation will not be started if the MDF is not available for the Classification Panel.

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

Note

The measurement of impairment seen during athlete evaluation must correspond to the diagnosis indicated below (table for Medical Information). If the medical documentation is incomplete, IFCPF reserves the right to request further information. In the absence of such information, the athlete will not be able to proceed with Athlete Evaluation.

Athlete Information

(to be prepopulated by the IFCPF Member)

Family Name:			
Given Name/s:			
Gender:	☐ Male ☐ Female	**Date of Birth:**	dd/mm/yyyy
Country:			
Athlete´s Status	☐ New (N) ☐ Review (R) -including RFD-		

Medical Information

Note: The list of medical diagnoses consists of 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)**
☐ Bilateral Spasticity ☐ Unilateral Spasticity ☐ Dystonia ☐ Athetosis ☐ Ataxia	☐ Cerebral Palsy ☐ Traumatic Brain Injury ☐ Stroke ☐ Other_____	☐ Medical Report ☐ Modified Ashworth Scale ☐ DIS (Dyskinesia Impairment Scale) ☐ SARA (Scale for Assessment and Rating of Ataxia) ☐ Cerebral MRI or CT scan ☐ Other_____

Medical History

Athlete´s condition is:	☐ Stable ☐ Progressive ☐ Fluctuating ☐ Permanent	
Age of onset:	yyyy	☐ 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 Speciality:			
Registration Number:			
Address:			
City:		**Country:**	
Phone:		**E-mail:**	
Date:		**Signature and Stamp:**	