

Department of Veterans Affairs **PARTICIPANT REGISTRATION FORM -- PHYSICAL EXAM**

NATIONAL VETERANS TEE TOURNAMENT
(To be completed by a Clinician. 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 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

Dear Examining Clinician: Your patient is planning to participate in a three-day event with moderately strenuous, sporting activities, provided that you concur. To ensure that this is an appropriate activity for this Veteran, please conduct a detailed review of his/her medical record. Thank you for assisting us in ensuring this participant's safety.

PATIENT'S NAME	SOCIAL SECURITY NUMBER <i>(Last 4 digits only)</i>	DATE
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PRIMARY DISABILITY/DIAGNOSIS: DATE OF ONSET _____

- VISUALLY IMPAIRED
 - LEGALLY BLIND TOTALLY BLIND RESIDUAL VISION
- 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
- PSYCHOLOGICAL CONDITIONS
 - PTSD ANXIETY DEPRESSION SEIZURES STROKE
- OTHER CONDITION(S) _____

- PLEASE RATE YOUR PATIENTS LEVEL OF INDEPENDENCE
- INDEPENDENT WITH SELF CARE NEEDS, INDEPENDENT ONCE ORIENTED
 - INDEPENDENT WITH SELF CARE NEEDS, NEEDS SIGHTED GUIDE OCCASIONALLY AFTER ORIENTATION
 - INDEPENDENT WITH SELF CARE NEEDS, NEEDS SIGHTED GUIDE CONTINUOUSLY

PATIENT NEEDS

PATIENT REQUIRES ATTENDANT? YES NO IF YES, ATTENDANTS' NAME _____

USES WHEELCHAIR MAJORITY OF TIME? YES NO

USES OTHER ADAPTIVE EQUIPMENT? YES NO IF YES, WHAT _____

PATIENT'S NAME	SOCIAL SECURITY NUMBER <i>(Last 4 digits only)</i>
MEDICAL HISTORY <i>(i.e., diabetes, heart disease, hypertension, respiratory difficulty)</i> _____ _____	
LIST ALL MEDICATIONS, INCLUDING ASPIRIN AND OTHER "OVER THE COUNTER" MEDICINE/SUPPLEMENTS _____ _____	
KNOWN ALLERGIES _____	
DATE OF LAST TETANUS SHOT _____	
IS THE PATIENT TAKING COUMADIN OR OTHER ANTICOAGULANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHICH _____	
DOES THE PATIENT SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ALCOHOL OR OTHER SUBSTANCE USE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICAL EXAM HEIGHT _____ <i>(inches)</i> WEIGHT _____ <i>(pounds)</i> PULSE _____ CARDIAC _____ BLOOD PRESSURE _____ HEAD & NECK _____ PULMONARY _____ ABDOMEN _____ EXTREMITIES _____ HEENT _____ NEURO _____ OTHER FINDINGS _____ _____	
IN MY OPINION, THE ABOVE INDIVIDUAL: <input type="checkbox"/> IS MEDICALLY FIT TO PARTICIPATE <input type="checkbox"/> IS NOT MEDICALLY FIT TO PARTICIPATE	
SIGNATURE OF EXAMING CLINICIAN	NAME OF EXAMING CLINICIAN <i>(Please print)</i>
ADDRESS OF EXAMINING CLINICIAN	TELEPHONE NUMBER