OMB Number:
Respondent Burden: 20 minutes

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 *(Last 4 digits only)*	DATE

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 *(Last 4 digits only)*

MEDICAL HISTORY *(i.e., diabetes, heart disease, hypertension, respiratory difficulty)*

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? ☐ YES ☐ NO IF YES, WHICH _____

DOES THE PATIENT SMOKE? ☐ YES ☐ NO

ALCOHOL OR OTHER SUBSTANCE USE? ☐ YES ☐ NO

PHYSICAL EXAM

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

CARDIAC _____ BLOOD PRESSURE _____

HEAD & NECK _____ PULMONARY _____

ABDOMEN _____ EXTREMITIES _____

HEENT _____ NEURO _____

OTHER FINDINGS

IN MY OPINION, THE ABOVE INDIVIDUAL:

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

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