



# 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 15 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
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PATIENT'S DAYTIME PHONE NUMBER (Include area code)	EVENING PHONE NUMBER	VAMC WHERE PATIENT RECEIVES CARE
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**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 <i>(Last 4 digits only)</i>
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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 \_\_\_\_\_

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 \_\_\_\_\_

CARDIOPULMONARY REVIEW OF SYSTEMS WAS DONE AND IS UNREMARKABLE     YES

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 HOSPITALIZATION 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](mailto: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 <i>(Please print)</i>
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HOSPITAL AND ADDRESS OF EXAMINING CLINICIAN	TELEPHONE NUMBER
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