

Medical Diagnostic Form for Athletes with a Physical Impairment

To be eligible for Para-cycling an Athlete must have an underlying medical diagnosis (Health Condition) that results in a Permanent and Eligible Impairment (Article 16.4.008 of the UCI Classification Rules and Regulations). The measurement of impairment conducted during the classification process must correspond to the diagnosis indicated below.

Completed forms and relevant Medical Diagnostic Information must be submitted to the UCI via the UCI file share server no later than four (4) weeks prior to the Competition where the Athlete plans to undergo Classification. The UCI holds the right to request further information, if additional information is required. The athlete will not be able to undergo Classification, until the requested information is provided.

Please fill in the form electronically.

Athlete Information (to be completed by the National Paralympic Committee/National Federation)

Family name:	
Given name/s:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
NPC/NF:	UCI ID:

Medical Information – to be completed in **English** by a registered Medical Doctor, M.D.

Athlete's Medical Diagnosis (Health Condition):	
Include description of body part/s affected and limitations:	
Primary Impairment/s arising from the Medical Diagnosis (Health Condition):	
<input type="checkbox"/> Impaired muscle power <input type="checkbox"/> Ataxia <input type="checkbox"/> Leg length difference <input type="checkbox"/> Impaired passive range of movement <input type="checkbox"/> Athetosis <input type="checkbox"/> Limb deficiency/loss <input type="checkbox"/> Hypertonia	
Medical condition is: <input type="checkbox"/> Permanent <input type="checkbox"/> Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Fluctuating	
Year of onset: <input type="checkbox"/> Congenital (birth)	

<p>Diagnostic Evidence to be attached:</p> <p>A Medical Diagnostic Report and Physical Examination results from a Health Professional qualified to examine the relevant impairment MUST be attached in English for ALL athletes to support the above diagnosis. Examples include</p> <ul style="list-style-type: none"> Completed ASIA scale for Athletes with Spinal Cord Injury, Medical Report indicating cause of impairment and available range of motion for Athletes with Impaired Passive Range of Movement, Australian Spasticity Assessment Scale (ASAS), reflex activity, presentation of clonus, tremor, rigidity, dystonia or dyskinesia for Athletes with Cerebral Palsy, X-rays for Athletes with dysmelia, or photo for Athletes with amputation. <p>UCI holds the right to request additional diagnostic evidence as per article 16.4.008 in UCI Classification Rules and Regulations, including but not limited to, report(s) from additional diagnostic testing (for example, EMG, MRI, CT, X-ray).</p>												
<p>Treatment History:</p>												
<p>Regular Medication – List dosage and reason:</p>												
<p>Presence of additional medical conditions/diagnoses:</p> <table border="0"> <tr> <td><input type="checkbox"/> Vision impairment</td> <td><input type="checkbox"/> Impaired respiratory function</td> <td><input type="checkbox"/> Joint Hypermobility/ instability</td> </tr> <tr> <td><input type="checkbox"/> Intellectual impairment</td> <td><input type="checkbox"/> Impaired metabolic functions</td> <td><input type="checkbox"/> Impaired muscle endurance</td> </tr> <tr> <td><input type="checkbox"/> Hearing impairment</td> <td><input type="checkbox"/> Impaired cardiovascular functions</td> <td>(e.g., Chronic fatigue)</td> </tr> <tr> <td><input type="checkbox"/> Psychological diagnoses</td> <td><input type="checkbox"/> Pain</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p>Describe:</p>	<input type="checkbox"/> Vision impairment	<input type="checkbox"/> Impaired respiratory function	<input type="checkbox"/> Joint Hypermobility/ instability	<input type="checkbox"/> Intellectual impairment	<input type="checkbox"/> Impaired metabolic functions	<input type="checkbox"/> Impaired muscle endurance	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Impaired cardiovascular functions	(e.g., Chronic fatigue)	<input type="checkbox"/> Psychological diagnoses	<input type="checkbox"/> Pain	<input type="checkbox"/> Other: _____
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<input type="checkbox"/> I confirm that the above information is accurate	
<p>Doctors Name:</p>	
<p>Medical Specialty:</p>	<p>Registration Number:</p>
<p>Address:</p>	
<p>City:</p>	<p>Country:</p>
<p>Phone:</p>	<p>E-mail:</p>
<p>Signature:</p>	<p>Date:</p>