

# WWR Medical Diagnostic Information Form

World Wheelchair Rugby requires medical diagnostic information for every athlete in order to confirm that the athlete has a permanent, verifiable health condition that results in an eligible impairment as defined by the WWR. WWR has determined that eligible impairment types are:

- Impaired muscle power
- Limb deficiency
- Impaired passive range of movement
- Ataxia, athetosis and hypertonia

This form must be completed in English by a registered medical doctor (M.D.), with a specialisation in the athlete's health condition (where possible).

The completed form with attached medical documentation must be provided to the WWR Head of Classification a minimum of 6 weeks prior to the athlete's first presentation at a WWR event licensed for Classification, where a WWR Classification Panel will be present.

The measurement of impairment seen during athlete evaluation MUST correspond to the diagnosis indicated on this form. If the medical documentation is incomplete, World Wheelchair Rugby 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:

Family name: (as shown on passport)			
First name: (as shown on passport)			
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:	(dd/mm/yyyy)
Country:			
<input type="checkbox"/> New athlete being classified for the first time	<input type="checkbox"/> Athlete has an existing WWR sport class		

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## Medical Information:

Note: The lists of medical diagnoses shown are examples and are not an exhaustive list.

Eligible Impairment (tick)	Name of medical diagnosis relevant to the impairment type (tick or add)	Documents/evidence to support the diagnosis (tick or add)
<input type="checkbox"/> Impaired Muscle Power	<input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Charcot Marie Tooth (HSMN) <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical report <input type="checkbox"/> ASIA scale <input type="checkbox"/> Electromyography <input type="checkbox"/> MRI/CT scan <input type="checkbox"/> X-rays <input type="checkbox"/> Biopsy <input type="checkbox"/> Other _____
<input type="checkbox"/> Limb Deficiency	<input type="checkbox"/> Dismelia <input type="checkbox"/> Traumatic amputation <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Other _____
<input type="checkbox"/> Impaired Passive Range of Movement	<input type="checkbox"/> Arthrogyrosis <input type="checkbox"/> Joint contractures <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Goniometric measures <input type="checkbox"/> Other _____
<input type="checkbox"/> Ataxia  <input type="checkbox"/> Athetosis  <input type="checkbox"/> Hypertonia	<input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical report <input type="checkbox"/> Modified Ashworth Scale <input type="checkbox"/> Cerebral MRI/CT scan <input type="checkbox"/> Other _____

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## Medical History:

Athlete's condition is:	<input type="checkbox"/> Stable	<input type="checkbox"/> Progressive	<input type="checkbox"/> Fluctuating	<input type="checkbox"/> Permanent
Age of Onset:			<input type="checkbox"/> Congenital	
Past treatments:	(years)			
Current treatments:				
Anticipated future treatments:				

**Additional details on medical diagnosis (if required):**

**Medications and reason for prescription:**

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## Certification:

<input type="checkbox"/> I confirm that the information provided is accurate and has not been edited or altered in any way.	
Name:	
Medical Specialty:	
Registration Number:	
Address:	
City:	Country:
Phone:	E-mail:
Date:	Signature: