LETTER TO BE PROVIDED TO YOUR DOCTOR

Dear Medical Practitioner

Special Olympics Australia is a not-for-profit organisation that provides sports training and competition for people with an intellectual disability across eighteen sports.

Anyone with an intellectual disability is welcome to participate, but they need to register. One of the conditions of registration is that the person must visit a medical practitioner to complete a Health Care Assessment Form every 4 years.. This is to confirm that they are fit and able to participate in sport.

The form was designed by the global Special Olympics medical community to assist medical practitioners to detect conditions that are common among people with an intellectual disability and that may go undetected in a standard physical examination.

We ask that as the medical practitioner you complete the Health Care Assessment Form (3 pages), identify if the athlete is fit to participate in sport and sign as required.

Your fees for this consultation can be claimed under the “Health Assessments” category of the Medicare Benefits Schedule. Relevant item numbers are:

- Item 703 Standard (30-45 minutes)
- Item 705 Long (45-60 minutes)
- Item 707 Prolonged (at least 60 minutes)

Thank you for your time. We appreciate your assistance in helping us ensure that the athletes of Special Olympics Australia are fit to play sport.

Yours sincerely
Pierre Comis
Chief Executive Officer

Athlete Details	TO BE COMPLETED BY ATHLETE/PARENT/GUARDIAN/CARER

Athlete Club _____

Athlete SOMS/Membership Number _____

_____

Healthcare Assessment Form

TO BE COMPLETED BY MEDICAL PRACTITIONER

Athlete's Name

Height | Weight | Temperature

Blood Pressure Right | Blood Pressure Left

Left vision 6 /12 or better ☐ Yes ☐ No ☐ N/A | Left hearing (Finger Rub) ☐ Responds ☐ No Response ☐ Can't Evaluate

Right vision 6/12 or better ☐ Yes ☐ No ☐ N/A | Right hearing (Finger Rub) ☐ Responds ☐ No Response ☐ Can't Evaluate

Left Ear Canal ☐ Clear ☐ Cerumen ☐ Foreign Body | Left Tympanic Membrane ☐ Clear ☐ Perforation ☐ Infection

Right Ear Canal ☐ Clear ☐ Cerumen ☐ Foreign Body | Right Tympanic Membrane ☐ Clear ☐ Perforation ☐ Infection

Left upper extremity reflex ☐ Normal ☐ Diminished ☐ Hyperreflexia | Right upper extremity reflex ☐ Normal ☐ Diminished ☐ Hyperreflexia

Left lower extremity reflex ☐ Normal ☐ Diminished ☐ Hyperreflexia | Right lower extremity reflex ☐ Normal ☐ Diminished ☐ Hyperreflexia

Abdominal Tenderness ☐ No ☐ Ruq ☐ Rlq ☐ Luq ☐ Llq

Kidney Tenderness ☐ No ☐ Right ☐ Left | Oral Hygiene ☐ Good ☐ Fair ☐ Poor | Splenomegaly ☐ Yes ☐ No

Bowel Sounds ☐ Yes ☐ No | Hepatomegaly ☐ Yes ☐ No | Thyroid Enlargement ☐ Yes ☐ No

Lymph Node Enlargement ☐ Yes ☐ No | Lungs ☐ Clear ☐ Not clear | Heart Rhythm ☐ Regular ☐ Irregular

Heart Murmur (supine) ☐ No ☐ 1/6 or 2/6 ☐ 3/6 or greater | Heart Murmur (upright) ☐ No ☐ 1/5 or 2/5 ☐ 3/5 or greater

Abnormal Gait ☐ No ☐ Yes, describe

Spasticity ☐ No ☐ Yes, describe

Tremor ☐ No ☐ Yes, describe

Neck & Back Mobility ☐ Full ☐ Not full, describe

Upper Extremity Mobility ☐ Full ☐ Not full, describe

Lower Extremity Mobility ☐ Full ☐ Not full, describe

Lower Extremity Strength ☐ Full ☐ Not full, describe

Upper Extremity Strength ☐ Full ☐ Not full, describe

Radial Pulse Symmetry ☐ Yes ☐ R>L ☐ L>R

Loss of Sensitivity ☐ No ☐ Yes, describe

Cyanosis ☐ No ☐ Yes, describe

Clubbing ☐ No ☐ Yes, describe

Left Leg Oedema ☐ No ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ | Right Leg Oedema ☐ No ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

Healthcare Assessment Form (continued)

TO BE COMPLETED BY MEDICAL PRACTITIONER

☐ Athlete does not have any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability

☐ Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and therefore must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

Please choose **ONE OPTION** to confirm if the athlete is able to participate in Special Olympics sport.

☐ This athlete is fit to participate in Special Olympics Australia sport.

OR

☐ This athlete has medical issues which require further investigation, however the athlete is able to participate in Special Olympics Australia sport.

A referral has been obtained ☐ Yes ☐ No

OR

☐ This athlete wishes to renew their athlete registration but is not fit to participate in Special Olympics Australia sport at this time and must be evaluated by a professional for the following concerns:

☐ Cardiac ☐ Stage II Hypertension or greater

☐ Neurological ☐ Other _____

A referral has been obtained ☐ Yes ☐ No

Signature of Medical Practitioner **Date**

Name

Email

Phone **Provider Number**

TO BE COMPLETED BY MEDICAL PRACTITIONER/ATHLETE/PARENT/GUARDIAN/CARER

Has the athlete ever had any of the following conditions?

Dizziness during or after exercise	☐ Yes ☐ No	Irregular, racing or skipped heart beats	☐ Yes ☐ No
Heart Valve Disease	☐ Yes ☐ No	Headache during or after exercise	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Chest pain during or after exercise	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No
Vision Impairment	☐ Yes ☐ No	Shortness of breath during or after exercise	☐ Yes ☐ No
Cardiomyopathy	☐ Yes ☐ No	Hearing Impairment	☐ Yes ☐ No
Endocarditis	☐ Yes ☐ No		
Any difficulty controlling bowels or bladder If yes, is this new or worse in the past 3 years?	☐ Yes ☐ No ☐ New ☐ Worse	Numbness or tingling in legs, arms, hands or feet If yes, is this new or worse in the past 3 years?	☐ Yes ☐ No ☐ New ☐ Worse
Weakness in legs, arms, hands or feet If yes, is this new or worse in the past 3 years?	☐ Yes ☐ No ☐ New ☐ Worse	Head Tilt If yes, is this new or worse in the past 3 years?	☐ Yes ☐ No ☐ New ☐ Worse
Paralysis If yes, is this new or worse in the past 3 years?	☐ Yes ☐ No ☐ New ☐ Worse	Epilepsy or any type of seizure disorder If yes, is this new or worse in the past 3 years?	☐ Yes ☐ No ☐ New ☐ Worse
Seizure during the past year If yes, is this new or worse in the past 3 years?	☐ Yes ☐ No ☐ New ☐ Worse	Spasticity If yes, is this new or worse in the past 3 years?	☐ Yes ☐ No ☐ New ☐ Worse

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet ☐ Yes ☐ No
If yes, is this new or worse in the past 3 years? ☐ New ☐ Worse

Is the athlete able to administer his or her own medications? ☐ Yes ☐ No

Athlete Signature (only if own guardian) **Date**

Legal Guardian Signature (only if not own guardian) **Date**

Athlete Details

TO BE COMPLETED BY ATHLETE/PARENT/GUARDIAN/CARER

Athlete Club

Athlete SOMS/Membership Number

Medical Referral

ONLY to be used if the athlete has not been cleared for sports participation

Athlete's Name

Examiners Name | Speciality

I have examined this athlete for the following medical concern(s)

Please describe

In my professional opinion, this athlete may participate in Special Olympics Australia sports (see to the right for restrictions or limitations) ☐ Yes ☐ No

Additional Practitioners Notes

Medical Practitioner's Signature | **Date**

Name

Email

Phone | **Provider Number**