MEDICAL DIAGNOSIS FORM

USEF PARA-EQUESTRIAN CLASSIFICATION

The athlete named below is required to undergo Classification in order to compete in Para-Equestrian sport. During the classification process, the approved Classifier (physiotherapist or medical doctor) will assess their physical impairment(s) as relevant to the requirements of the athlete's discipline. Each athlete must have an Eligible Impairment that leads to permanent and verifiable activity limitation(s) which can be measured objectively through the classification process.

Relevant and appropriate medical documentation is essential to the process of Classification. Confirmation of the medical diagnosis and a summary of results of relevant medical investigations supporting the diagnosis and/or impairments is required. In some instances, a copy of a report from medical tests, or specialists (e.g. neurologist), is also required.

Athlete's Details (Completed by the Athlete applying for classification - Please print)

First Name	Last Name
Discipline	Please circle DRESSAGE DRIVING REINING
Gender ___ Male ___ Female	Date Of Birth
Address	
City	State Zip
Telephone	E-mail
I hereby consent to the information below being released to the USEF or the FEI for the purpose of Para-Equestrian Classification.	
Athlete Signature	Date
USEF No.	

MEDICAL DETAILS **Completed by Medical Doctor only – please print** Please attach a separate sheet or report if insufficient space

Physician Specialty	
Patient Diagnosis / Health Condition(s) Onset _____	
Test results to support the above diagnosis e.g MRI, CT, Muscle biopsy, nerve conduction, ASIA scale	

Condition is (please circle all that apply)	Permanent	Stable	Progressive Fluctuating
Other relevant factors e.g. therapeutic, surgical, or pharmacological interventions			
Impairments arising from the diagnosis	___ muscle power / strength ___ passive range of motion ___ hypertonia	___ ataxia ___ athetosis ___ short stature (height _____)	___ leg length difference ___ limb deficiency / loss
Additional health conditions, impairments, or diagnoses	___ Vision ___ Emotional / Behavioral ___ Other:	___ Hearing ___ Hypermobility / joint instability	___ Cognition / memory ___ Pain

Please print or stamp

Athlete Name	
Physician Name	
License/NPI #	
Address	
Phone/Email	
I have followed this patient for _____ years and confirm that the above information is accurate.	
Signature	
Date	

Information disclosed here and attached will be dealt with confidentially by the USEF and in accordance to the IPC Code of Ethics for Classification.

Please return this form and attached documents to:

Laureen K. Johnson
Director of Para-Equestrian, USEF
22 Rutherford Drive, Belvidere, NJ 07823

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email lkjohnson@usef.org

Revised Jan 2019