



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 (PT, OT or MD) 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 (e.g. MRI, EMG), 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		
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

MEDICAL DETAILS Completed by Medical Doctor only – please print

Attach a separate sheet or report if insufficient space

Physician Specialty	
Patient Diagnosis / Health Condition(s) Onset _____ For MS: circle one CIS RRMS SPMS PPMS	
Test results to support the above diagnosis e.g MRI, CT, Muscle biopsy, nerve conduction, For Spinal Cord: 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	<input type="checkbox"/> muscle power / strength	<input type="checkbox"/> ataxia	<input type="checkbox"/> leg length difference	<input type="checkbox"/> limb deficiency / loss
	<input type="checkbox"/> passive range of motion	<input type="checkbox"/> athetosis	<input type="checkbox"/> short stature (height _____)	
	<input type="checkbox"/> hypertonia			
Additional health conditions, impairments, or diagnoses	<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Cognition / memory	<input type="checkbox"/> Pain
	<input type="checkbox"/> Emotional / Behavioral	<input type="checkbox"/> Hypermobility / joint instability		
	<input type="checkbox"/> Other:			

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:

Lauren K. Johnson
Director of Para-Equestrian, USEF
PO Box 83
Gladstone, NJ 07934
t 859-225-7693 f 908 234 9417
email lkjohnson@usef.org