

# National Level Para Powerlifting Medical Diagnostic Form for All Athletes with Physical Impairment

To be eligible for Para powerlifting an athlete must have an underlying medical diagnosis (Health Condition) that results in a Permanent and Eligible Impairment (article 7 in the World Para Powerlifting Classification Rules and Regulations). The measurement of impairment conducted during the classification process must correspond to the diagnosis indicated below.

## Athlete Information

<b>Family name:</b>	
<b>Given name/s:</b>	
<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Date of Birth:</b> _____ (dd/mm/yyyy)
<b>NPC:</b>	<b>SDMS ID:</b>

## Medical Information (to be completed in English by a registered Medical Doctor)

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

**Diagnostic Evidence to be Attached:**

Evidence to support the above diagnosis must be attached in English for all athletes:

- Medical Diagnostic Report and Physical Examination results (for example ASIA scale for Athletes with Spinal Cord Injury, Ashworth Scale for Athletes with Cerebral Palsy, X-rays for Athletes with dysmelia, photo for Athletes with amputation)
  
- Report(s) from additional diagnostic testing (for example, EMG, MRI, CT, X-ray)

**Treatment History:**

**Regular Medication – List dosage and reason:**

**Presence of additional medical conditions/diagnoses:**

- Vision impairment
- Intellectual impairment
- Hearing impairment
- Psychological diagnoses
- Impaired respiratory function
- Impaired metabolic functions
- Impaired cardiovascular functions
- Pain
- Joint Hypermobility/ instability
- Impaired muscle endurance (e.g., Chronic fatigue)
- Other: \_\_\_\_\_

**Describe:**

I confirm that the above information is accurate

**Doctor Name:**

**Medical Specialty:**

**Registration Number:**

**Address:**

**City:**

**Country:**

**Phone:**

**E-mail:**

**Signature:**

**Date:**