



## Medical Diagnostics Form for ALL Athletes with Physical Impairment

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

Completed forms and relevant Medical Diagnostic Information must be uploaded to the athlete's SMS profile upon registration of the athlete to the WA-SMS. World Para Dance Sport holds the right to request further information, if additional information is required. The athlete will not be able to undergo classification, until such time as the requested information is provided.

**Please fill in the form electronically**

### Athlete Information (to be prepopulated by the NPC/NF)

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

Medical Information – to be completed **in English** by a registered Medical Doctor, M.D.

<b>Athlete's Medical Diagnosis (Health Condition)</b>	
<b>Include description of the 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	

#### World Abilitysport

Aylesbury College, Oxford Road, Aylesbury  
Buckinghamshire, HP321 8PD UK

[worldabilitysport.org](http://worldabilitysport.org)  
[worldabilitysport.org/sports/international-federation/world-para-dance-sport](http://worldabilitysport.org/sports/international-federation/world-para-dance-sport)

<p><b>Diagnostic evidence to be attached:</b>  Evidence to support the above diagnosis <b>MUST</b> be attached in <b>English</b> for <b>ALL</b> athletes:  <input type="checkbox"/> 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)  World Para Dance Sport holds the right to request additional diagnostic evidence as per Article 7.5 and 7.6 in World Para Dance Sport Classification Rules and Regulations, included but not limited to:  <input type="checkbox"/> Report (s) from additional diagnostic testing (for example, EMG, MRI, CT, X-ray).</p>												
<p><b>Treatment History:</b></p>												
<p><b>Regular Medication – List dosage and reason:</b></p>												
<p><b>Presence of additional medical conditions/ diagnoses:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Vision Impairment</td> <td style="width: 33%;"><input type="checkbox"/> Impaired respiratory function</td> <td style="width: 33%;"><input type="checkbox"/> Joint Hypermobility instability</td> </tr> <tr> <td><input type="checkbox"/> Intellectual Impairment</td> <td><input type="checkbox"/> Impaired metabolic function</td> <td><input type="checkbox"/> Impaired muscle endurance</td> </tr> <tr> <td><input type="checkbox"/> Hearing Impairment</td> <td><input type="checkbox"/> Impaired cardiovascular functions</td> <td style="text-align: center;">(e.g. Chronic fatigue)</td> </tr> <tr> <td><input type="checkbox"/> Psychological diagnoses</td> <td><input type="checkbox"/> Pain</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p><b>Describe:</b></p>	<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Impaired respiratory function	<input type="checkbox"/> Joint Hypermobility instability	<input type="checkbox"/> Intellectual Impairment	<input type="checkbox"/> Impaired metabolic function	<input type="checkbox"/> Impaired muscle endurance	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Impaired cardiovascular functions	(e.g. Chronic fatigue)	<input type="checkbox"/> Psychological diagnoses	<input type="checkbox"/> Pain	<input type="checkbox"/> Other: _____
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<input type="checkbox"/> <b>I confirm that the above information is accurate.</b>	
Doctors name:	
Medical Specialty:	
Registration Number:	
Address:	
City:	Country:
Phone:	E-mail:
Signature:	Date: