Medical Information (MF2)

For Transplant Athletes

This information is requested from the Doctor who is in charge of your transplant follow-up. The form must be completed and signed not earlier than six (6) months before the event and returned to the LOC Office **before 16 April 2017.**

Please note: This information will be carefully reviewed prior to the competitor's registration. If the information provided is incomplete, the athlete will not be permitted to register.

COMPETITOR'S DETAILS (please circle when appropriate):

First Name: Last Name:

Date of Birth: / / (dd/mm/yyyy) Sex: M / F

Original Disease: First Transplant / Re-transplant

Date of last Transplant: / / (dd/mm/yyyy) Deceased / Living transplant,

Type: Kidney; Lung; Heart; Liver; Bone-marrow (from a donor), Pancreas & islet cell; Small Bowel

Address:

Email: Mobile:

Emergency Contact Telephone number:

Next of Kin: Name: Ph No: ( )

Current Medications: Please see MF1 or attach complete list including complementary medicines.

Allergies/Diet		Competitor's Height (cm)	
		Competitor's Weight (kg)	

LABORATORY DATA (input level of each test):

Creatinine		Blood Sugar	
eGFR (Glomerular Filtration Rate)		HbA1c (if DM))	
Haemoglobin		Cyclosporine Level (trough)	
ALT		FK Level (trough)	
AST		Hepatitis B (HBsAg)	+ / -
Bilirubin		Hepatitis B (anti-HBs)	+ / -
Alkaline Phosphatase		Hepatitis C (anti-HCV)	+ / -

CARDIO-VASCULAR AND RESPIRATORY STATUS (attach report if any):

History of High Blood Pressure		YES		NO
Results of the most recent coronary angiogram or cardiac isotopic scan and date		Procedure: PTA / STENT / CABG – Yes / No Date:		
Baseline Blood Pressure (<150/90)		Lying		Standing	
Ejection fraction of left ventricle (EFLV)				
Rhythm abnormalities:				
Pulmonary function (if lung disease or lung transplant)	FEV1	Vital Capacity		

OTHER MEDICAL PROBLEMS

e.g. Diabetes Mellitus, Epilepsy, Asthma:

MEDICAL ADVISOR'S DETAILS

Name: Signature:

Institute:

Address:

Telephone: ( ) Fax: ( )

Email: Date: