

## National Veterans Wheelchair Games Medical Forms and Clearance



Dear Provider,

You are being asked to medically clear your patient to participate in the National Veterans Wheelchair Games (NVWG). The National Veterans Wheelchair Games provides opportunities for health and healing through 22 adaptive sports competitions and exhibition events reflecting adaptive sports opportunities available to Veterans in their home communities for year-long participation.

Participation is open to Veterans having spinal cord injuries, lower extremity amputations, multiple sclerosis, or other central neuro-muscular conditions. Physical disabilities must be permanent and measurable and require a wheelchair for sport participation. All Veterans registering for the National Veterans Wheelchair Games must be eligible to receive care at a VA medical facility. When a Veteran's diagnosis and eligibility to compete is in question, we will refer to the eligibility criteria appropriate for that person to participate in other community wheelchair sports organizations. Medical clearance must be provided by a physician, physician assistant or a nurse practitioner. A full and complete neuromuscular exam must be completed on all Veterans new to the NVWG and without a permanent classification. The neuromuscular exam portion can be provided by a physical therapist.

All activities include physical exertion and training is highly recommended prior to participating in the event. If the Veteran is new to the NVWG, we recommend a consult to a rehabilitation therapist/specialist to assist developing a conditioning program appropriate to their goals and level of participation.

### **Medical Conditions that meet NVWG eligibility criteria include:**

- Spinal Cord Injury (must include if complete or incomplete paraplegia or quadriplegia, Level of Injury and ASIA Impairment Scale (AIS)).
- Cerebrovascular Accident (CVA)
- Traumatic Brain Injury (w/impairments requiring a wheelchair for sports)
- Amputee (excludes toe amputations or upper extremity)
- Amyotrophic Lateral Sclerosis (ALS)
- Multiple Sclerosis (w/impairments requiring a wheelchair for sports)
- Other neurologic disorders causing disabling neuromuscular function (case by case)

### **Medical Conditions that do NOT meet the criteria for participation in the NVWG:**

- Functional Movement Disorder (Conversion Disorder)
- Hip, knee and ankle surgeries/replacements
- Degenerative Joint Disease (DJD)
- Degenerative Disc Disease (DDD)
- Radiculopathy
- Peripheral neuropathy
- Osteoarthritis (OA)
- Pain syndromes (Central Pain Syndrome (CPS), Fibromyalgia, Chronic Low Back Pain (CLBP), etc.)
- Low Vision
- Diabetes Mellitus (DM)
- Mental Health (as primary diagnosis and/or only diagnosis)
- Cardiovascular/Respiratory disease
- Systemic/Metabolic disease
- Spinal Stenosis if no physical impairment requiring wheelchair is present
- Rheumatologic conditions and other systemic joint conditions

If at any time the medical condition of your patient changes so that they would not be safe to participate, please contact the NVWG office at 206-407-9542. If you have any questions regarding your patient's medical clearance you can contact the NVWG Medical Director.

Regards,

Kenneth Lee, MD  
Medical Director, National Veterans Wheelchair Games  
[Kenneth.Lee8@va.gov](mailto:Kenneth.Lee8@va.gov)

## National Veterans Wheelchair Games Medical Forms and Clearance



**Registration:**        [OPENS - Jan 11, 2022](#)

[CLOSES – Apr 1, 2022](#)

We are providing you with the General Medical and Physical (2 pages) forms so you can schedule your appointment with your provider. If you are also applying to attend another National Veterans Sports Program and Special Events program (i.e. Winter Sports Clinic), **please have the provider complete this application at the same time.** We will only accept the NVWG Medical and Physical forms.

**Do NOT mail your General Medical and Physical Forms until Jan 11!**

**A FULL & COMPLETE** application includes **ALL** the **CURRENT** year forms. Incomplete applications will DELAY your application being processed and **event assignments are not given until a complete application is received.**

### Application Checklist - Tips to Complete

#### **General Medical and Physical (2 pages)**

Intro page on General Medical Form (page 1, top section) **MUST** be completed by the participant.

**ALL areas must be completed EVEN** if you've attended before!

- Date** (date you are completing, it is critical we obtain a current year evaluation)
- VA Medical Center** (the main VA where you obtain care)
- Full Last Name, First Name, Middle Initial**
- YOUR Address** (not the VA medical center's)
- E-mail** (your e-mail associated with your online registration/account)
- VA Member Number**
- Date of Birth**
- Telephone** (provide the number we can reach you)
- Team Coordinator** (your VA coach or therapist or PVA team representative)
- Team Coordinator's phone and e-mail** (this helps if we have questions)
- Emergency Contact**

**Page 2** – Only a Physician, Physician Assistant or Nurse Practitioner can complete your medical forms. Signature, address, date and a phone number **IS required.** Neuromuscular exam is **REQUIRED for NEW** athletes / applicants. The neuro exam can be completed by a Physical Therapist.

**The following forms will be available on Jan 11<sup>th</sup>!** Each requires name, signature and date.

- Consent for Production (2 pages)
- Waiver & Release of Liability (2 pages)
- Damage Provision (1 page)
- Concussion Awareness Information (2 pages)



Department of Veterans Affairs

**GENERAL MEDICAL FORM**

*TO BE COMPLETED BY PARTICIPANT. PLEASE TYPE OR PRINT CLEARLY.*

**PRIVACY ACT:** VA is asking you to provide the information on this form under USC, Chapter 5, Section 521 and Chapter 17, Section 1710. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 121VA19 "National Patient Databases - VA". Providing the requested information is voluntary. However, you will not be able to participate in the event without furnishing this information.

**RESPONDENT BURDEN:** The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 10 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

DATE		VA MEDICAL CENTER NAME	
NAME (Last, First, MI)		ADDRESS (Street, City, State, Zip Code)	
E-MAIL ADDRESS			
VA MEMBER ID NUMBER (VA Card)	DATE OF BIRTH	TELEPHONE NUMBER (Include area code)	
TEAM COORDINATOR/LEADER:	TELEPHONE NUMBER	E-MAIL ADDRESS	
In Case of Emergency, Notify (Name):	TELEPHONE NUMBER	RELATIONSHIP TO PATIENT	

*TO BE COMPLETED BY THE EXAMINING PHYSICIAN. PLEASE TYPE OR PRINT CLEARLY.*

**Dear Doctor:** Your detailed exam of the participant will be very helpful to the medical assistance team. If an assistant completes the form, please countersign the exam.

**DIAGNOSIS/TYPE OF INJURY**  
 DATE OF INJURY OR DIAGNOSIS \_\_\_\_\_  
 SPINAL CORD INJURY (SCI)-LEVEL OF INJURY: \_\_\_\_\_ AIS: \_\_\_\_\_  
 PARAPLEGIC     QUADRAPLEGIC  
 MULTIPLE SCLEROSIS (MS)  
 AMPUTEE  
 HEAD INJURY  
 OTHER (Please specify) \_\_\_\_\_

**VA IDENTIFICATION CARD**

**PLEASE ATTACH A COPY OF VA IDENTIFICATION CARD HERE**

**\*\* Must include your VA member ID number.**

**MEDICATIONS** (List relevant medications only. Please do NOT submit VA medications list)

If accepted to participate in the NVWG and your medical condition changes between now and the NVWG, it is your responsibility to check with your physician and modify your events as appropriate. The NVWG is a sports competition that requires physical exertion. For the best outcomes and your safety, you should be training to participate in your particular events. Please consult your physician or therapist for recommendations and assistance.

# PHYSICAL FORM

WEIGHT	HEIGHT	LUNGS	HEART	SKIN
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OTHER FINDINGS

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**PRESENT AND PAST MEDICAL HISTORY AND MAJOR OPERATIONS** *(Diabetes, heart disease, hypertension, etc.)*

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IS THE PATIENT ON DIALYSIS?\* *(Patient is responsible for setting up any dialysis treatment needed)*     YES     NO  
 IS THE PATIENT ON A VENTILATOR?     YES     NO  
 IS THE PATIENT ON ANTICOAGULANT DRUGS? *(If yes, which)*     YES     NO

**PHYSICIAN CLEARANCE**  
 In my opinion, the above individual is cleared to participate in the events they have indicated on their NVWG registration.

**PHYSICIAN INFORMATION**  
 VA     NON-VA  
 NAME OF EXAMINING PROVIDER *(Please print) (Check appropriate box)*  

MD     PA     NP

 ADDRESS *(Street, City, State and Zip Code)*  
 SIGNATURE OF EXAMINING PROVIDER  
 TELEPHONE NUMBER                      DATE

**NVWG AND/OR USQRA CLASSIFICATION CARD(S)**

**PLEASE ATTACH A COPY OF YOUR CLASSIFICATION CARD(S)**  
*(See below)*

If applicable, please attach a **copy** (not the original) of you National Veterans Wheelchair Games, USQRA (quad rugby), and/or Wheelchair Sports, USA classification card above.

May omit only if copy of current NVWG Classification card is provided.

*This section must be completed by someone familiar with direct muscle testing, i.e., a physician, physical therapist, kinesiologist, or occupational therapist.*

**NEURO EXAM (Manual muscle test, 0-5)**

UPPER EXTREMITY	RIGHT	LEFT	LOWER EXTREMITY	RIGHT	LEFT
DELTOID	_____	_____	HIP FLEXION	_____	_____
BICEPS	_____	_____	HIP EXTENSION	_____	_____
WRIST EXTENSION	_____	_____	HIP ADDUCTION	_____	_____
WRIST FLEXION	_____	_____	HIP ABDUCTION	_____	_____
TRICEPS	_____	_____	KNEE FLEXION	_____	_____
FINGER EXTENSION	_____	_____	KNEE EXTENSION	_____	_____
FINGER FLEXION	_____	_____	DORSIFLEXION	_____	_____
FINGER ABD/ADD	_____	_____	PLANTARFLEXION	_____	_____

<b>SITTING BALANCE</b> <i>(Please check one)</i>	<b>HANDEDNESS</b> <i>(Please check one)</i>	<b>TRUNK (0-5 scale)</b>
<input type="checkbox"/> NORMAL <input type="checkbox"/> FAIR	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	<b>UPPER</b> <b>LOWER</b>
<input type="checkbox"/> POOR <input type="checkbox"/> NONE		ABDOMINALS                      _____
		SPINAL EXTENSORS                      _____