AUSTRALIAN PARALYMPIC COMMITTEE

Classification

National VI Medical Screening Form
Athletes with a vision impairment

This form must be completed by a registered Ophthalmologist.

This information is used to assist in determining the athlete's classification in accordance with the respective International sports classification rules. In the event that an athlete has difficulty accessing an Ophthalmologist, the form may be completed by an alternative Ophthalmic professional.
However, athletes must also provide historical documentation from an Ophthalmologist that confirms their diagnosis.

Athletes must submit this form to the authorised Australian VI Classifier each time an athlete presents to VI classification.

- An athlete cannot be classified unless they present with all of the information below, either by way of this form or separate report.

Any questions about classification should be directed to the APC on 08 8415 6803 or classification@paralympic.org.au

PLEASE FILL OUT THIS FORM IN CAPITAL LETTERS OR TYPING

Athlete Personal Details		
Surname:	First Name:	
Address:		
Suburb:	State:	Postcode:
Phone (h)	Phone (mob):	
E-mail:		
Date of Birth: ___/___/_____	Age:	
Medical Information		
Current diagnosis with supporting medical evidence. **See note 1**		
Medical history		
Age of onset:		
Anticipated future procedure(s):		
Eye medication:		
Allergies:		
Optical Aids: circle as appropriate Glasses Contact lenses Sun glasses Sports goggles Prosthesis		
Correction RIGHT_____ LEFT_____		

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Clinical Examination	
Visual acuity without correction RIGHT_____ LEFT_____	
Visual acuity with correction RIGHT_____ LEFT_____	
Refraction RIGHT_____ LEFT_____	
Type of correction:	
Measurement method:	
Visual field: Diameter, in degrees (if applicable). **See note 2** RIGHT_____ LEFT_____ Visual fields are to be attached as per note 2	
Please specify the athletes eye condition: ☐ Anterior Disease ☐ Macular Disease ☐ Peripheral Retina Disease ☐ Optic Nerve Disease ☐ Cortical / Neurological disease	Has the athlete undergone any of the following testing: ☐ Macular OCT ☐ Multifocal ERG ☐ Full field ERG ☐ Pattern ERG ☐ Pattern VEP ☐ Pattern appearance VEP *If yes to the above please provide results as per note 1*

Ophthalmologist Declaration		
Full Name:		
Qualifications:		
Business address:		
Suburb:	State:	Postcode:
Phone (w):		
☐ I certify that the above-mentioned information is medically appropriate ☐ I certify that there is no contra-indication for this individual to compete at competitive level in preferred sport.		
Signature of Ophthalmologist: Date:		

Note 1 Diagnosic Confirmation

- Evidence confirming the diagnosis must be attached and forwarded with this application.

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- The medical evidence should include a comprehensive medical history and the results of all relevant examinations, laboratory investigations and imaging studies. Evidence should be as objective as possible in the clinical circumstances and in the case of non-demonstrable conditions independent supporting medical opinion will assist this application.

- This may include the results and sample recordings of the following where they are needed to establish and confirm a diagnosis:
  - Pattern Visual Evoked Potentials
  - Electroretinography / Electrooculography
  - Cerebral MRI

Note 2 Visual Field

- Visual Field is to be tested by full-field strategy by means of any of the following devices:
  - Humphrey Field Analyzer, Twinfield (Oculus), Octopus (interzeag), Rodenstock Peristat, Medmont (MAP), Goldmann Perimetry Intensity III/4
- Attach copy of results from Humphrey Visual Field or Goldmann Visual Field assessment – at 120, 30, 24 and 10 on each eye.
  -30° central field test is not accepted
  -Visual Field is only provided where this is clinically appropriate.