

CERTIFICATE OF DIAGNOSIS

FOR PARA-EQUESTRIAN CLASSIFICATION

The person named below is required to undergo Para-Equestrian Classification to compete at National level of their chosen sport. During the classification process the approved Classifier (physiotherapist or medical doctor) will assess their physical impairment as relevant to the requirements for riding a horse. To assist the classification assessment process a confirmation of the medical diagnosis and a summary of results of relevant medical investigations to support the diagnosis is required. In some instances, a copy of a report from a medical specialist e.g. neurologist, will be required.

Athlete's Details

To be completed by the Athlete applying for classification – Please print in black pen

First Name		Family Name			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date Of Birth			
Address					
City		Postcode		Nation	
Telephone No		E-mail			
I hereby consent to the information below being released to Equestrian Australia for the purpose of Para-Equestrian Classification.					
Signature:				Date:	

MEDICAL DETAILS

This section to be completed by a Doctor of Medicine only– please print clearly

Relevant and appropriate medical documentation is essential to the process of Classification of Athletes for National Para-Equestrian Competition. Athletes must have a health condition that is verifiable and resulting in a permanent impairment and thereby the principle effects are lifelong.

This medical information should provide the results of medical tests and investigations which demonstrate that the Athlete has a diagnosis of a medical condition which leads to their presenting physical impairments.

Please attach a separate sheet or report if insufficient space

Name of Athlete	
List the Athlete's presenting health conditions	
Test results to support the above diagnosis e.g. MRI, CT, Muscle biopsy, nerve conduction, ASIA assessment (attach if required)	
List resulting permanent impairments (for example- hypertonia, ataxia, athetosis, muscle power, passive range of movement, limb deficiency, short stature, and leg length difference).	
Other relevant information	

I hereby certify that I have followed this patient for _____ years and that the above named patient has the diagnosis specified above.

Please print

Doctor's Name:	
Address:	
Signature:	
Date:	

N.B. Information disclosed on this form will be stored confidentially by EA.