EUROPEAN TRANSPLANT AND DIALYSIS GAMES MEDICAL FORM

FIRST NAME: LAST NAME: TELEPHONE NUMBER:

TYPE OF TRANSPLANT: TRANSPLANT UNIT: CONSULTANT:

All types of organ transplants (for consultants)

DATE OF RESULTS:

EGFR (EXCLUDING DIALYSIS PATIENTS) OR: CREATINE (EXCLUDING DIALYSIS PATIENTS)

HB: BP:

☐ MUSCULO-SKELETAL DISORDER: ☐ DIABETES: ☐ INSULIN:

☐ EPILEPSY: ☐ ASTHMA: ☐ CARDIAC HISTORY:

VISION: SPECIAL REQUIREMENTS:

Medication

☐ TACROLIMUS DOSE:

☐ CICLOSPORIN DOSE:

☐ MYCOPHENOLATE DOSE:

☐ AZATHIOPRINE DOSE:

☐ PREDNISOLONE DOSE:

☐ OTHER DRUGS DOSE:

☐ ANTICOAGULATION THERAPY

RECENT INR: ALLERGIES:

Heart and Lung Patients only

CARDIOANGIOGRAPHY / MRI:

EXHOCARDIOGRAPHY:

EXERCISE ECG:

LUNG FUNCTION TESTS:

Liver Patients only

BILIRUBIN:

ALK PHOS:

ALT:

AST:

Bone Marrow Patients only

WBC:

NEUTROPHILS:

PLATELETS:

Pancreas Patients only

GLUCOSE LEVEL:

Dialysis Patients only

TYPE OF DIALYSIS:

IF ON HAEMODIALYSIS, WHICH DAYS DO YOU DIALYSE ON?

Medical Advisor's Comments

PLEASE COMMENT ON GRAFT FUNCTION AND SUITABILITY TO COMPETE:

IF ON DIALYSIS, PLEASE CONFIRM THAT THE PARTICIPANT IS STABLE WITH GOOD BLOOD PRESSURE, FLUID AND BIOCHEMICAL CONTROL:

Confirmation

- [ ] CONSULTANT - I CONFIRM THE INFORMATION IN THIS FORM IS CORRECT
- [ ] PATIENT - I CONFIRM THE INFORMATION IN THIS FORM IS CORRECT
- [ ] PARENT - I CONFIRM THE INFORMATION IN THIS FORM IS CORRECT