MEDICAL RECORD (MF4)

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 four (4) months before the event and returned to the LOC Office by **3rd July 2015**

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

First Name: _____ Last Name: _____
Date of Birth: ____/____/_____
Address: _____
Email: _____
Emergency Contact Telephone number: _____ Mobile: _____
Next of Kin: Name: _____ PhNo:(_____)_____
Date of Transplant: ___/___/_____Type: Kidney; Lung; Heart; Liver; Bone-marrow; Pancreas

Current Medications (all): *Please attach complete list including complementary medicines*

Allergies/Diet		Competitor's Height	
		Competitor's Weight	

LABORATORY DATA

Creatinine (<300)*		Alkaline Phosphatase		
eGFR (Glomerular Filtration Rate)**>40				
Haemoglobin(>10g/dl)		FC/Cyclosporine Level		
ALT		Hepatitis B	+	-
AST		Hepatitis C	+	-
Bilirubin }		Blood Sugar		

* Higher acceptable if stable ** Lower acceptable if stable

CARDIO-VASCULAR AND RESPIRATORY STATUS

History of High Blood Preassure	YES		NO	
Coronary artery disease: results of the most recent coronary angiogram of cardiac isotopic scan and date				
Baseline Blood Pressure (<150/90)	Lying		Standing	
Ejection fraction of left ventricle (EFLV)				
Rhythm adnormalities:				
Pulmonary function (if lung disease)(FEV1.,VC)	Vital Capacity			
PTA/Stent/CABG	YES		NO	

OTHER MEDICAL PROBLEMS e.g. Diabetes Mellitus,Epilepsy, Asthma

MEDICAL ADVISOR'S DETAILS

Name: _____ Signature: _____
Address: _____
Telephone: (____)_____ Fax: (____)_____
Email: _____ Date: _____