12th World Transplant Winter Games
BORMIO 2024

Transplant Athlete Medical Form

Please note that your medical forms must be completed ONLINE here.

You MUST visit the Doctor-in-charge of your transplant follow-up in order to get your accurate medical data and ensure that your Doctor is happy for you to compete in your chosen sports. Completion of these forms confirms that you have indeed visited your doctor to obtain this information.

Medical Forms must be completed by close of registration (12 January 2024)

The information on your medical forms will be reviewed prior to confirmation of your ability to compete. If the information is incomplete you will not be allowed to participate in the Games.

Before competing in the World Transplant Winter Games, it is expected that your general health and fitness are stable as judged by your transplant follow-up doctor. Your health is to be measured by the tests performed by your follow-up doctor and, if necessary, your follow-up cardiologist or sports doctor. You are responsible for maintaining your own training program, preferably in conjunction with a sporting advisor/coach.

You should adapt your training program to match your chosen sports. The 3 stress levels are shown below:

LOW STRESS:

* Curling

MEDIUM STRESS:

* Snowshoe

HIGH STRESS:

* Ski Slalom / Ski Giant Slalom / Ski Super Giant Slalom / Ski Parallel Slalom

* Snowboard Giant Slalom / Snowboard Parallel Slalom

* Cross Country Ski 5km / Cross Country Ski 1 hour / Cross Country 3km team

* Biathlon

COMPETITOR DETAILS

Team Country *

URN (Unique Reservations Number received by email when you registered for the Games eg: GMS2134) *

Name *

First Name

Last Name

Date of Birth: *

MM/DD/YYYY

Date

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Gender *

- Male
- Female
- Other

Email *

example@example.com

Mobile (include international dialling code) *

Emergency Contact Name *

Emergency Contact Relationship *

Emergency Contact Number (include international dialling code) *

TRANSPLANT DETAILS

Date of transplant *

MM/DD/YYYY

Type of Transplant *

- [ ] Bone Marrow / Stem Cell
- [ ] Double Lung
- [ ] Heart
- [ ] Heart / Lung
- [ ] Intestine
- [ ] Kidney
- [ ] Liver
- [ ] Single Lung
- [ ] Pancreas
- [ ] Pancreas and Kidney
- [ ] Pancreas Islet Cell
- [ ] Other

FITNESS INFORMATION

*I certify that I take part in regular physical activity as follows:

Times per week: *

Minutes per session: *

I am training at a stress level of: *

- [ ] Low
- [ ] Medium
- [ ] High

I take part in the following sports for leisure / competitively *

Type here...

I intend to take part in the following sports in Bormio, Italy *

Type here...

MEDICATION

*Please complete the table below: *

	Name of Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			

12			
13			
14			
15			
16			
17			
18			
19			
20			

MEDICAL INFORMATION

Please answer Yes or No to the following questions: *

	YES	NO
Are you pregnant	○	○
Are you on anticoagulants	○	○
Do you have diabetes melitus	○	○
Do you have ischaemic heart disease	○	○
Do you have epilepsy	○	○
Do you have asthma	○	○

If you have had a heart or lung operation - please provide details?

Please state any medication you are allergic to?

Do you have a history of COVID-19 Infection *

- Yes
- No

If yes, provide date of last infection

MM-DD-YYYY

Date

If applicable, please state the number of COVID 19 vaccinations doses you have had

Brand of last dose?

Date of last dose?

MM-DD-YYYY

Date

LABORATORY DATA

Results of all tests are required.

All results should be from tests performed after 01 November 2023.

*Please complete the table below

	Result	Unit of Measurement	Date of test
Creatinine / eGFR: (Glomerular Filtration Rate)			

Haemoglobin			
ALT - Liver Recipients ONLY			
AST - Liver Recipients ONLY			
Bilirubin - Liver Recipients ONLY			
Alkaline Phosphatase			
Blood sugar			
HbA1c (if diabetic)			

Hepatitis B (HBsAg) *

- [ ] Yes
- [ ] No

RESULT of Hepatitis B (HBsAg) *

- [ ] Positive
- [ ] Negative

Hepatitis C (anti-HCV) *

- [ ] Yes
- [ ] No

RESULT of Hepatitis C (anti-HCV) *

- [ ] Positive
- [ ] Negative

Cyclosporine Level (target)

Tacrolimus Level (target)

CARDIO-VASCULAR & RESPIRATORY STATUS

Baseline Blood Pressure: *

History of High Blood Pressure? *

- [ ] Yes
- [ ] No

Pulmonary Function (HEART/LUNG, LUNG TRANSPLANT ONLY)

	Results
FEV1:	
Vital Capacity:	

CARDIAC STRESS TEST

A cardiac stress test is not essential in those with a history of coronary artery disease or over the age of 50 undertaking medium and high stress sports events.

However, it may be recommended by your local physician in appropriate cases and if performed the results should be declared below.

Will you be completing a cardiac stress test? *

- [ ] Yes
- [ ] No

If you selected NO - you are required to tick the box below acknowledging that you understand the risk of not performing the stress test, as suggested.

Yes I understand

Cardiac Stress Test Results:

	Results
Maximum Strength tolerated and duration:	
Percentage of maximal theoretic frequency:	
Reason for stopping test:	
ECG – rhythm abnormality: YES / NO	
Resting pulse and maximal:	

**** Upload a copy of your Cardiac Stress Test results below ****

Upload Cardiac Stress Test Results:

Browse Files

Drag and drop files here

Files allowed: pdf, doc, docx, xls, xlsx, csv, txt, rtf, html, zip, wma, mpg, flv, avi, jpg, jpeg, png

For those with an abnormal stress test, please supply results of the most recent coronary angiogram or cardiac isotopic scan and date.

*Please complete the table below:

	Procedure	Date	Results
1			
2			
3			

Ejection fraction of left ventricle (EFLV)

Rhythm abnormalities

MEDICAL DOCTORS DETAILS

Medical Doctor Name *

Hospital / Institute *

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Telephone Number (include international dialling code) *

Email *

example@example.com

Date of consultation *

MM/DD/YYYY

Date

I confirm that my medical doctor carried out an examination at the date of consultation indicated above, agreed I am fit to compete in my selected events, and provided me with all the medical information required in this document. *

- [ ] Yes
- [ ] No

Data Storage and Participation in Clinical Research

Please note that all relevant GDPR requirements will be followed in the management of medical forms.

I agree that my data will be transferred to an online system for access and used by the World Transplant Winter Games 2024 medical / physio team for the sole purpose of providing treatment, if required, for the duration of the Games. *

- [ ] Yes

I am willing to be approached to participate in clinical research during the World Transplant Winter Games 2024? *

- [ ] Yes
- [ ] No

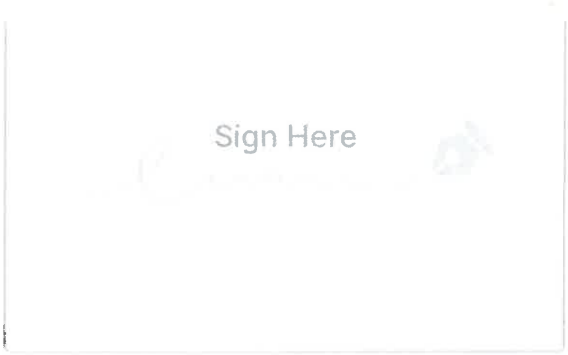
I agree that after the Games my data may be stored in a non-identifiable format and may be used for future studies by the World Transplant Games Federation authorised researchers? *

- [ ] Yes
- [ ] No

DECLARATION

I confirm that the information provided is true and accurate to the best of my knowledge and, where required, information is provided by a qualified medical doctor.

Electronic Signature *



Clear

Date *

MM/DD/YYYY

Date

Save Submit

HIPAA COMPLIANCE