Medical Information (MF2)

For Transplant Athletes
To be returned to the Vancouver LOC by **May 15, 2018**.
All medical forms should be scanned and saved as a PDF.
Please email to medforms@txworks.ca or print and mail to:
CTA Games 2018, c/o 151 East Osborne Road, North Vancouver, BC, V7N1L8

CANADIAN TRANSPLANT ASSOCIATION / L'ASSOCIATION CANADIENNE DES GREFFÉS

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 six (6) months before the event and returned to the LOC Office before May15th 2018. **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 (please circle when appropriate)

First Name: Last Name:
Date of Birth: / / (dd/mm/yyyy) Sex: M / F
Original Disease: First Transplant / Re-transplant
Date of last Transplant: / / Deceased / Living transplant
Type: kidney; lung; heart; liver; bone marrow; pancreas & islet cell; small bowel
Address:
Email: Mobile:
Emergency Contact Name: Phone: ( )

Current Medications: *Please see MF1 or attach complete list (incl. complementary medicines).*

Allergies/Diet		Height (cm)	
		Weight (kg)	

LABORATORY DATA (input level of each test)

Creatinine		Blood Sugar	
eGFR (Glomerular Filtration Rate)		HbA1c (if DM))	
Hemoglobin		Cyclosporine Level (trough)	
ALT		FK Level (trough)	
AST		Hepatitis B (HBsAg)	+ / -
Bilirubin		Hepatitis B (anti-HBs)	+ / -
Alkaline Phosphatase		Hepatitis C (anti-HCV)	+ / -

CARDIOVASCULAR AND RESPIRATORY STATUS (attach report if any)

History of High Blood Pressure		YES	NO	
Results of the most recent coronary angiogram or cardiac isotopic scan		Procedure: PTA / STENT / CABG – Yes / No Date:		
Baseline Blood Pressure (<150/90)		Lying	Standing	
Ejection fraction of left ventricle (EFLV)				
Rhythm abnormalities:				
Pulmonary function (if lung disease/transplant)	FEV1	Vital Capacity		

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

MEDICAL ADVISOR'S DETAILS

Name: Signature:
Hospital:
Address:
Telephone: ( ) Fax: ( )
Email: Date: