OREGON STATE POLICE
Oregon State Athletic Commission
500 Airport Rd SE
Salem OR
TELEPHONE: 503-871-5091
FAX: 503-540-1440

PRE-FIGHT BRAIN CT SCAN INTERPRETATION FORM

NOTE: Only a licensed radiologist, neurologist or neurosurgeon may complete this form

NAME:_____ **EXAM DATE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **COUNTRY:** _____

PHONE: _____ **DATE OF BIRTH:** _____

***IS THIS CT EXAMINATION WITHIN NORMAL LIMITS?** **YES** ☐ ☐ **NO** ☐

IS FURTHER REFERRAL OR EXAMINATION NEEDED? **YES** ☐ ☐ **NO** ☐

IF SO, FURTHER RECOMMENDATIONS INCLUDE:

_____

_____

_____

_____

_____

BASED ON THIS CT, THE FIGHTER:

☐ **IS** ☐ **IS NOT** **MEDICALLY CLEARED TO PARTICIPATE**

Physicians Name: _____

Physician Signature: _____

Address: _____ **City:** _____

State: _____ **Country:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

***PLEASE INCLUDE A COPY OF THE ACTUAL CT EXAMINATION REPORT WITH THIS FORM**

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PRE-FIGHT BRAIN MRI INTERPRETATION FORM

NOTE: Only a licensed radiologist, neurologist or neurosurgeon may complete this form

NAME:_____ **EXAM DATE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **COUNTRY:** _____

PHONE: _____ **DATE OF BIRTH:** _____

TYPE OF MRI CONDUCTED? _____

***IS THIS MRI EXAMINATION WITHIN NORMAL LIMITS?** □ **YES** □ **NO**

IS FURTHER REFERRAL OR EXAMINATION NEEDED? □ **YES** □ **NO**

IF SO, FURTHER RECOMMENDATIONS INCLUDE:

_____

_____

_____

_____

_____

BASED ON THIS MRI, THE FIGHTER:

□ **IS** □ **IS NOT** **MEDICALLY CLEARED TO PARTICIPATE**

Physicians Name: _____

Physician Signature: _____

Address: _____ **City:** _____

State: _____ **Country:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

***PLEASE INCLUDE A COPY OF THE ACTUAL MRI EXAMINATION REPORT WITH THIS FORM**

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PRE-FIGHT NEUROLOGICAL EVALUATION FORM

(Form must be completed by a neurologist or neurosurgeon)

NAME: _____ **DATE:** _____

AGE: _____ **HANDED: RIGHT** _____ **LEFT** _____

YEARS BOXING: _____ **FIGHT RECORD:** _____ **LAST FIGHT:** _____

OCCUPATION: _____

COMMENTS: _____

_____

_____

NEUROLOGICAL EXAMINATION:

VITAL SIGNS: BP: _____/_____ **PULSE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

MENTAL STAUTS EXAM: □ **NORMAL** □ **ABNORMAL**
CRANIAL NERVES: □ **NORMAL** □ **ABNORMAL**
MOTOR EXAM: □ **NORMAL** □ **ABNORMAL**
DTR EXAM: □ **NORMAL** □ **ABNORMAL**
CEREBELLAR: □ **NORMAL** □ **ABNORMAL**
SENSORY EXAM: □ **NORMAL** □ **ABNORMAL**
GAIT EXAM: □ **NORMAL** □ **ABNORMAL**

COMMENTS: _____

_____

_____

THE FIGHTER: □ **IS** □ **IS NOT** **MEDICALLY CLEARED TO PARTICIPATE**

Physicians Name: _____

Physician Signature: _____

Address: _____ **City:** _____

State: _____ **Country:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

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PRE-FIGHT ELECTROCARDIOGRAM (EKG) INTERPRETATION FORM

NAME:_____ EXAM DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ COUNTRY: _____

PHONE: _____ DATE OF BIRTH: _____

EKG INTERPRETATION:

☐ **WITHIN NORMAL LIMITS**

IF NOT WITHIN NORMAL LIMITS, PLEASE REPORT ABNORMALITIES BELOW:
(CHECK ALL THAT APPLY)

☐	**NSR**	☐	**LAD**
☐	**Sinus Brady**	☐	**LBBB**
☐	**Sinus Tachycardia**	☐	**Incomplete RBBB**
☐	**Sinus Arrest**	☐	**RBBB**
☐	**Sinus Arrhythmia**	☐	**LVH**
☐	**S-A Block**	☐	**LVH with Strain**
☐	**SVT**	☐	**RVH**
☐	**PAC's**	☐	**RVH with Strain**
☐	**A-Fib**	☐	**Cor Pulmonale**
☐	**A-Flutter**	☐	**Acute Infarct**
☐	**Junctional Rhythm**	☐	**Infarct - Recent**
☐	**PVC's**	☐	**Infarct - Old**
☐	**V-Tach**	☐	**Ischemic T-wave Abn**
☐	**V-Fib**	☐	**Non-Specific T-wave Abn**
☐	**V-Arrhythmia**	☐	**Non-Specific S-T Segment Abn**
☐	**1° A-V Block**	☐	**Q-T > .44**
☐	**Mobitz Type I**	☐	**Abnormal P-Wave**
☐	**Mobitz Type II**	☐	**Electrolyte Effect**
☐	**Complete Block**	☐	**Technically Limited Study**
☐	**QRS > .10**	☐	**Un-interpretable**

BASED ON THIS EKG, THE FIGHTER:
☐ **IS** ☐ **IS NOT** **MEDICALLY CLEARED TO PARTICIPATE**

If Not, Further Recommendations Include: _____

Physicians Name: _____

Physician Signature: _____

Address: _____ City: _____

State: _____ Country: _____ Zip: _____

Phone: _____ Fax: _____

Forms Courtesy of :
Dr. Michael Schwartz
Co-Chairman – Medical Advisory Committee