Australian Transplant Games
3-10 October 2010
Competitorôs Medical Certificate

This certificate must be filled in by your Doctor in **August** and returned to Transplant Australia (PO Box 592, North Sydney NSW 2059) by Friday 27 August 2010

Competitorôs Details: *Please print clearly*

Surname: _____ Given Names: _____

Date of Birth: _____ Age: _____

Address: _____ Suburb: _____

State: _____ Post Code: _____ Email: _____

Phone Home: ( ) _____ Work: ( ) _____ Mobile: _____

Medical Details: (type of transplant)
Kidney ☐ Heart ☐ Liver ☐ Pancreas ☐ Lung ☐ Double Lung ☐ Bone Marrow ☐
Heart/Lung ☐ Tissue (including cornea and bone) ☐ Cystic Fibrosis ☐ Dialysis ☐

Date of Transplant: _____ Transplant Unit: _____

Name of physician: _____

Competitorôs Height (cm): _____ Weight (kgs): _____

Creatinine (.300u/Mol/L): _____ Hb (>10hm.dl): _____ BP(<150/90): _____ Hbs Ag: _____

Musculo-skeletal Disorders: _____

LFTôs, Enzymes, Bilirubin not more that 10% above normal levels: _____

Angiography (no significant coronary artery narrowing): _____

Diabetes: Yes ☐ No☐

Allergies: Yes ☐ No☐ If yes, please list: _____

List of Medications (including dose) please use the back of this page if you need more room: _____

_____

_____

Medical Adviserôs Comments, please use the back of this page if you need more room:

_____

_____

Medical Adviserôs Details: Name: _____ Designation: _____

Address: _____

I certify that the above named athlete is fit to compete in their chosen sports.

Signed: _____ Dated: _____ Telephone: ( ) _____