Kentucky Boxing and Wrestling Commission

500 Mero St, 218NC

Frankfort, Ky 40601

Phone: (502) 564-0085

Fax: (502) 696-3938

Email: kbwc@ky.gov

www.kbwc.ky.gov

Neurological Evaluation Form

Only a licensed neurologist or neurosurgeon can conduct this examination and complete this form. Please complete this form in its entirety. All information must be typed or legibly printed and **all questions must be answered**. Submit form to the following address: *KBWC 500 Mero St, 2NC18, Frankfort, Ky 40601* or the examining physician's office can fax the form to 502-696-3938.

Combatant's Full Name:

_____

First Name Middle Name Last Name

Social Security #: _____ Birth Date: _____ Age: _____

Professional Ring Name: _____

Phone: _____ E-mail: _____

Mailing Address: _____

_____

City County State Country Zip Code

History:

Is there anything in this combatant's past medical history that would cause you to recommend that the combatant not be licensed in Kentucky? [ ] Yes [ ] No
Please explain:

_____

_____

_____

Examination:

Cranial Nerves:

1. Pupillary size in MM OD ____ OS ____ Reactivity OD ____ OS ____

Note any asymmetry_____

N/A ___

2. Fundus OD ____ OS ____ N/A ___

3. Eye closure _____

N/A ___

4. Extraocular motility visual pursuit _____ saccades _____ nystagmus _____

Describe any abnormality _____

N/A ___

5. Palate elevation N/A ___

Motor:

6. Strength RUE _____ LUE _____ FILE _____ LLE _____ (0 – 5/5)

List any abnormality _____

N/A ___

7. Tone RUE _____ LUE _____ FILE _____ LLE _____
(I = increased D = decreased N = normal) N/A ___

8. Range of motion RUE _____ LUE _____ FILE _____ LLE _____

Describe reason for restriction _____

N/A ___

9. Abnormal movements (tics, chorea, choreiform, myoclonus, etc.)

_____

Fasciculation _____

Describe any abnormal movements _____

N/A ___

Cerebellar:

10. Finger – nose – finger

Describe any abnormalities_____ N/A ___

11. Heel – shin

Describe any abnormalities_____ N/A ___
Abnormal = 3 failures

12. Rebound check

Describe any abnormalities_____ N/A ___
Abnormal = 2 failures

13. Rapid alternating hand movements

Describe any abnormalities_____ N/A ___

14. One foot hop (3 trails, 5 seconds each foot)

Describe any abnormalities _____ N/A ___

15. Romberg Describe any abnormalities _____ N/A ___

Gait:

16. Gait

Routine Gait _____ Heal Walk _____ Toe Walk _____ Tandem Walk _____

Note any abnormal movements, including upper extremity (i.e.: dystonic posturing, athetosis)

_____ N/A _____

Sensation:

17. Sensation _____ N/A_____

Deep Tendon Reflexes:

18. Deep Tendon Reflexes _____ N/A _____

19. Babinski _____ N/A _____

Other Observations:

20. List any other symptoms or evidence of neurological abnormalities from history or observations.

_____

_____

_____

_____

_____

_____

MENTAL STATUS EXAMINATION:

Maximum Score

1. What is the (year) (season) (date) (month) ____/4

2. Where are we (state) (county) (city) (hospital) (floor) _____/5

3. Name 3 objects: (e.g., cow, apple, bus) – one second to say each __/3

Then ask applicant all three after you have said them.
(One point for each correct answer) Then repeat them until he/she learns all 3.

Count trials and record. Trials = _____

4. Serial 7's. (One point for each correct) Stop after 5 attempts ____/5

5. Ask for the 3 objects repeated above (one point for each correct) ____/3

6. Name a pencil and a watch ____/2

7. Repeat: "No ifs, ands, or buts" _____/1

8. Follow a 3 stage command: 3 ____

"Take a paper in your right hand. Fold it in half, and put it on the floor."

9. Copy Design ____/1

Total Score ____
(021 suggestions cognitive impairment)

Examining Physician:

Based on your personal observation and review of the test results and considering Kentucky Boxing and Wrestling Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports?
[ ] Yes [ ] No If no, please explain:

_____

_____

_____

_____

Physician's Full Name:

_____

First Name Middle Name Last Name

Medical License Number _____

Physician's Address:

_____

_____

City County State Country Zip Code

Physician's Signature

_____

_____

Date/ Time