CULTURAL AND COMMUNITY ENGAGEMENT • SPENCER J. COX, GOVERNOR

PETE SUAZO UTAH ATHLETIC COMMISSION
3760 S. Highland Drive, 3th Floor | MILLCREEK, UTAH 84106
Phone: (801) 538-8607 Fax: (801) 408-0849
Website: http://www.psuac.com Email: PSUAC@utah.gov

NEUROLOGICAL EXAMINATION REPORT

Only a licensed physician in Utah may conduct this examination and complete this form.
Please complete this form in its entirety.

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO psuac@utah.gov OR FAX TO (801) 408-0849.

Last Name **First Name** **Date of Birth**

Street Address **City** **State** **Zip Code**

HISTORY

Is there anything in this athlete's past medical history that would cause you to recommend that the athlete not be licensed in Utah?
Yes **No** If yes, please explain: _____

NEUROLOGICAL EXAMINATION

CRANIALNERVES (1 – 5)

1. **Pupillary size in MM** **OD** _____ **OS** _____ ***Reactivity*** **OD** _____ **OS** _____
   Note any asymmetry _____ **N/A** _____**(1)**
2. **Fundus** **OD** _____ **OS** _____ **N/A** _____**(2)**
3. **Eye closure** _____ **N/A** _____**(3)**
4. **Extraocular motility** visual pursuit _____ saccades _____ nystagmus _____
   Describe any abnormality _____ **N/A** _____**(4)**
5. **Palate elevation** **N/A** _____**(5)**

MOTOR (6 – 9)

6. **Strength** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____ **(0 – 5/5)**
   List any abnormality _____ **N/A** _____**(6)**
7. **Tone** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____
   (I = increased D = decreased N = normal) **N/A** _____**(7)**
8. **Range of motion** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____
   Describe reason for restriction _____ **N/A** _____**(8)**
9. **Abnormal movements** (tics, chorea, choreiform, myoclonus, etc.) _____
   Fasciulations _____
   Describe any abnormal movements _____ **N/A** _____**(9)**

CEREBELLAR (10 – 15)

10. **Finger – nose – finger** *Describe any abnormalities* _____ **N/A** _____**(10)**
11. **Heel – shin** *Describe any abnormalities* _____ **N/A** _____**(11)**
    Abnormal = 3 failures
12. **Rebound check** *Describe any abnormalities* _____ **N/A** _____**(12)**
    Abnormal = 2 failures
13. **Rapid alternating hand movements**
    Describe any abnormalities _____ **N/A** _____**(13)**
14. **One foot hop (3 trails, 5 secs ea ft)**
    Describe any abnormalities _____ **N/A** _____**(14)**
15. **Romberg** *Describe any abnormalities* _____ **N/A** _____**(15)**

NEUROLOGICAL EXAMINATION

APPLICANT NAME: _____

GAIT (16)

16. Gait

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

Note any abnormal movements, including upper extremity (ie: dystonic posturing, athetosis)

_____ **N/A _____(16)**

SENSATION(17)

17. Sensation_____ **N/A _____(17)**

DEEP TENDON REFLEXES (18 – 19)

18. Deep Tendon Reflexes _____ **N/A _____(18)**

19. Babinski _____ **N/A _____(19)**

OTHER OBSERVATIONS (20)

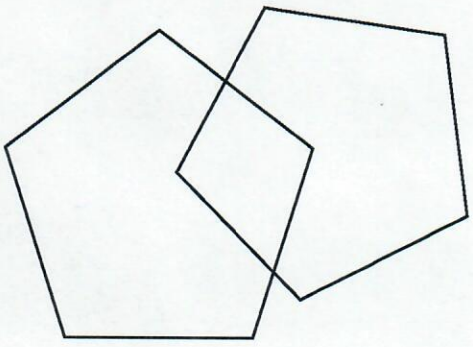
20. List any other symptoms or evidence of neurological abnormalities from history or observations.

_____ **N/A _____(20)**

MENTAL STATUS EXAMINATION

MINI-MENTAL STATUS EXAM (1 - 9)

		Maximum Score	Score
1.	What is the (year) (season) (date) (month)	5	_____
2.	Where are we (state) (county) (city) (hospital) (floor)	5	_____
3.	Name 3 objects: (e.g., cow, apple, bus) – one second to say each 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 = _____	3	_____
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: "TAKE A PAPER IN YOUR RIGHT HAND. FOLD IT IN HALF, AND PUT IT ON THE FLOOR"	3	_____
9.	Copy Design	1	_____



TOTAL SCORE _____

(0-21 suggests cognitive impairment) **N/A____ (1-9)**

NEUROLOGICAL EXAMINATION

APPLICANT NAME: _____

EXAMINING PHYSICIAN

As a licensed physician in Utah **I DO or DO NOT** *(circle one)* believe that this applicant could be permitted to be licensed in Utah.

Is further referral necessary? _____

Are additional exams needed? _____

I certify under penalty of perjury under the laws of the State of Utah that I am a licensed physician. MD or DO

_____ _____
Licensed Physician Name (Print) Medical License Number

_____ _____
Signature of Physician Date

_____ ( )
(Street Address) City State Zip Phone #

NEUROLOGICAL EXAMINATION ACKNOWLEDGEMENT

This examination is required for licensure and renewal of licensure of every professional athlete in the State of Utah.

I understand: _____ (Print your Name)

1. That the purpose of this screening examination is to detect possible early neurological changes resulting from cumulative head trauma which occur over extended periods of time and also changes that may affect my ability to engage in a professional boxing and/or martial arts match. This examination may uncover neurological findings that might hinder my ability to defend myself in a professional boxing and/or martial arts match.
2. That this examination does not predict possible future changes such as dementia, language difficulties, and problems with movement and coordination. Nor does it rule out the possibility of acute head trauma, such as subdural hematoma.
3. That this examination does not take the place of the general physical examination or diagnosis or medical treatment necessary for my general health or for any physical or mental condition I may otherwise have.
4. That the physician who is conducting this examination is not my personal physician and is not providing medical services to me.
5. That the results of this examination will be forwarded to the Pete Suazo Utah Athletic Commission for those purposes.
6. That any additional examinations, diagnostic procedures or treatment, including those which may be necessary for licensure as determined by the commission for the diagnosis and treatment of any physical or mental condition I may have, will only be done at my request and at my expense.

I have read and understand the statements made above.

_____ _____
Signature of Athlete **Date**

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO psuac@utah.gov OR FAX TO (801) 538-8607.