



PETE SUAZO UTAH ATHLETIC COMMISSION
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NEUROLOGICAL EXAMINATION REPORT

Only a licensed physician who specializes in neurology or neurosurgery 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

CRANIAL NERVES (1 - 5)

- 1. Pupillary size in MM OD OS Reactivity OD OS
2. Fundus OD OS
3. Eye closure
4. Extraocular motility visual pursuit saccades nystagmus
5. Palate elevation

MOTOR (6 - 9)

- 6. Strength RUE LUE FILE LLE (0 - 5/5)
7. Tone RUE LUE FILE LLE
8. Range of motion RUE LUE FILE LLE
9. Abnormal movements (tics, chorea, choreiform, myoclonus, etc.)

CEREBELLAR (10 - 15)

- 10. Finger - nose - finger Describe any abnormalities
11. Heel - shin Describe any abnormalities
12. Rebound check Describe any abnormalities
13. Rapid alternating hand movements Describe any abnormalities
14. One foot hop (3 trails, 5 secs ea ft) Describe any abnormalities
15. Romberg Describe any abnormalities

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)

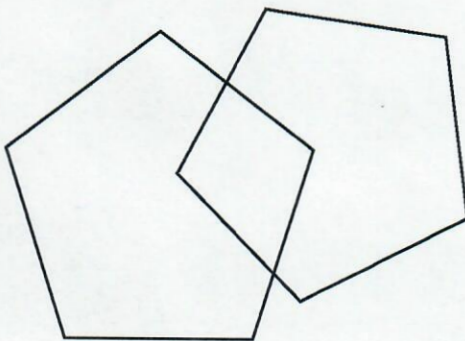
OTHER OBSERVATIONS (20)

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 that specializes in neurology or neurosurgery.

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

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