NEW YORK STATE OF OPPORTUNITY.

New York State Athletic Commission

New York State
Department of State
State Athletic Commission
123 William Street
New York, NY 10038-3804
Telephone: (212) 417-5700

PRE-FIGHT NEUROLOGY CLEARANCE FORM

*For neurology clearance to fight in New York State, a physician **Board Certified in Neurology** should complete this form in its **entirety.** *Please bring a copy of your **most recent MRI.***

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 New York? ☐ YES ☐ NO

If yes, please explain:_____

Date of MRI Brain Diagnostic Report: _____

Is the MRI Brain examination within normal limits? ☐ **YES** ☐ **NO**

If no, please explain: _____

NEUROLOGICAL EXAMINATION

CRANIAL NERVES

1. **Pupillary size in MM: OD _____ OS _____**

   Reactivity: OD ☐ *normal* ☐ *abnormal* **OS** ☐ *normal* ☐ *abnormal*

*Note any asymmetry:*_____

2. **Fundus: OD** ☐ *normal* ☐ *abnormal* **OS** ☐ *normal* ☐ *abnormal*
3. **Eye closure:** ☐ *normal* ☐ *abnormal*
4. **Extraocular motility: Visual pursuit** ☐ *normal* ☐ *abnormal*

   Saccades ☐ *normal* ☐ *abnormal*

   Nystagmus ☐ *normal* ☐ *abnormal*

*Describe any abnormality:*_____

5. **Facial symmetry, Palate elevation,**
   Shoulder shrug, Tongue Protrusion: ☐ *normal* ☐ *abnormal*

*Describe any abnormality:*_____

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MOTOR

6. **Strength: RUE _____ LUE _____ RLE _____ LLE _____ (0 – 5/5)**

*List any abnormality:*_____

7. **Tone: RUE _____ LUE _____ RLE _____ LLE _____**
   (I = increased ; D = decreased ; N = normal)

8. **Range of motion: RUE _____ LUE _____ RLE _____ LLE _____**
   (I = increased ; D = decreased ; N = normal)

*Describe reason for restriction:*_____

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

*Describe any abnormal movements:*_____

CEREBELLAR

10. **Finger – Nose – Finger:** ☐ *normal* ☐ *abnormal*

*Describe any abnormalities:*_____

Heel – Shin: ☐ *normal* ☐ *abnormal* (Abnormal = 3 failures)

*Describe any abnormalities:*_____

Rebound check: ☐ *normal* ☐ *abnormal* (Abnormal = 2 failures)

*Describe any abnormalities:*_____

11. **Rapid alternating hand movements:** ☐ *normal* ☐ *abnormal*

*Describe any abnormalities:*_____

12. **One-foot hop:** (3 trails, 5 seconds on each foot)

Rt foot ☐ *normal* ☐ *abnormal* **Lt foot** ☐ *normal* ☐ *abnormal*

*Describe any abnormalities:*_____

13. **Romberg:** ☐ *normal* ☐ *abnormal*

*Describe any abnormalities:*_____

GAIT

14. **Gait: Routine Gait** ☐ *normal* ☐ *abnormal* **Heel Walk** ☐ *normal* ☐ *abnormal*

Toe Walk ☐ *normal* ☐ *abnormal* **Tandem Walk** ☐ *normal* ☐ *abnormal*

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

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SENSATION

15. Sensation: ☐ *normal* ☐ *abnormal*

DEEP TENDON REFLEXES

16. Deep Tendon Reflexes: ☐ *normal* ☐ *abnormal*

17. Babinski: ☐ *normal* ☐ *abnormal*

OTHER OBSERVATIONS

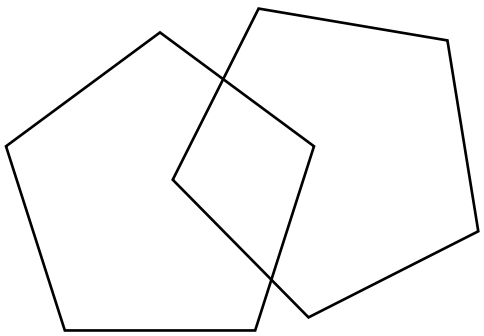
18. List any other symptoms or evidence of neurological abnormalities from history or observations:_____

_____

MENTAL STATUS EXAMINATION

MINI-MENTAL STATUS EXAM

	Maximum Score	Score
What is the (year)(season)(day of the week)(date)(month)	**5**	_____
Where are we (country)(state)(city)(hospital)(floor)	**5**	_____
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)	**3**	_____
Serial 7's (One point for each correct) Stop after 5 attempts	**5**	_____
Ask for the 3 objects repeated above (One point for each correct)	**3**	_____
Name a pencil and a watch (point to the objects)	**2**	_____
Repeat: "NO IFS, ANDS, OR BUTS"	**1**	_____
Follow a 3-stage command: "TAKE A PAPER IN YOUR RIGHT HAND. FOLD IT IN HALF, AND PUT IT ON THE FLOOR"	**3**	_____
Copy Design:	**1**	_____



TOTAL SCORE: _____ /28
(0-21) Suggests Cognitive Impairment)

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EXAMINING NEUROLOGIST

☐ As a licensed physician specializing in **Neurology, I DO** believe that this applicant could be permitted to be licensed in New York.

OR

☐ As a licensed physician specializing in **Neurology, I DO NOT** believe that this applicant could be permitted to be licensed in New York.

Is further referral necessary? ☐ **YES** ☐ **NO**

If yes, please explain: _____

_____

Are additional exams needed? ☐ **YES** ☐ **NO**

If yes, please explain: _____

_____

LICENSED NEUROLOGIST'S NAME (PRINT) | MEDICAL LICENSE NUMBER / STATE OF ISSUE

SIGNATURE OF NEUROLOGIST | DATE

STREET ADDRESS | CITY | STATE | ZIP

PHONE NUMBER