GEORGIA ATHLETIC AND ENTERTAINMENT COMMISSION
2 MARTIN LUTHER KING JR DR. SUITE 802, WEST TOWER
ATLANTA GA 30334
PHONE (470) 312-2702 FAX (470) 312-2701

NEUROLOGICAL EXAMINATION REPORT

(Must be administered by a licensed physician who specializes in neurology or neurosurgery)

_____

Last Name First Name Date of Birth

_____

Street Address City State Zip Code

HISTORY

Does the Patient have a history of seizure disorders? If yes explain_____

If so, when was the last time the Patient had a seizure? _____

Does the Patient have a history of high blood pressure? _____

If so, do they have a primary care physician and is the high blood pressure stable? _____

Is there anything in this athlete's past medical history that would cause you to recommend that the athlete not be licensed in Georgia?

Yes No (Circle One)
Please explain:

_____

NEUROLOGICAL EXAMINATION

CRANIAL NERVES (1 – 5)

1. Pupillary size in MM OD _____ OS____ Reactivity OD _____ OS _____

Note any asymmetry_____ (1) N/A

2. Fundus OD _____ OS _____ (2) N/A

3. Eye closure _____ (3) N/A

4. Extraocular motility visual pursuit_____ saccades _____ nystagmus ____

Describe any abnormality_____ (4) N/A

5. Palate elevation (5) N/A

MOTOR (6 – 9)

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

List any abnormality_____ (6) N/A

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

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

Describe reason for restriction_____ (8) N/A

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

Fasciulations_____

Describe any abnormal movements _____ (9) N/A

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)

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)

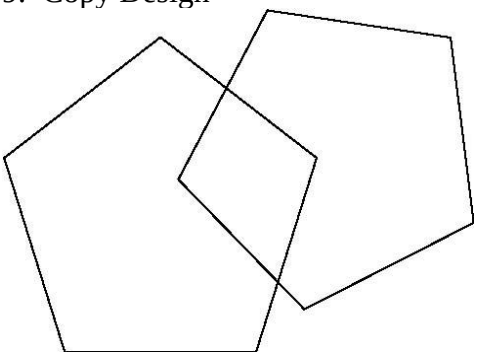
20. List any other symptoms or evidence of neurological abnormalities from history or observations.

_____ 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



TOTAL SCORE _____
(0-21 suggests cognitive impairment)
N/A____(1-9)

Athlete's Name: _____

EXAMINING NEUROLOGIST OR NEUROSURGEON

☐ As a licensed physician specializing in neurology or neurosurgery (circle one), I believe that this applicant could be permitted to be licensed in Georgia

☐ As a licensed physician specializing in neurology or neurosurgery (circle one), I DO NOT believe that this applicant could be permitted to be licensed in Georgia

Is further referral necessary? _____

Are additional exams needed? _____

I certify under penalty of perjury under the laws of the State of Georgia that I am a licensed physician and that I specialize in neurology or neurosurgery.

_____
Licensed Neurosurgeon or Neurologist's Name (Please Print)

_____ _____
Medical License Number Date

_____

Signature of Neurosurgeon or Neurologist

( )

_____

Street Address City State Zip

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NEUROLOGICAL EXAMINATION ACKNOWLEDGEMENT

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

I understand:

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 Georgia Athletic and Entertainment 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

Revised 2/2013