The following annexes (I, J, and K) are used to classify athletes for the 2016 DoD Warrior Games. General methodology is below:

1. Review Games Rules and Classification criteria (particularly Appendix A, I, J, K)

2. Complete athlete classification as per Appendix J, Classification SOP ("Classification Testing Protocol)".

3. Supplemental Information Packet for Classifiers, Appendix K will be useful to document athlete exam findings and classification information.

4. All testing data must be documented to the Athlete Classification Form (Appendix I). Once exam and classification findings are complete ensure all classifications are annotated on first page of Athlete Classification Form.

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

2016 DOD WARRIOR GAMES: CLASSIFICATION FORM

ATHLETE CLASSIFICATION FORM

This page to be completed by the athlete prior to classification testing

ATHLETE DEMOGRAPHIC INFORMATION

Athlete Name: _____Athlete Contact Number: (___) _____-_____

Gender: ☐ Male ☐ Female

Athlete Team: ☐ USAF ☐ USA ☐ USMC ☐USN ☐ USSOCOM

Disability Diagnosis/Diagnoses: _____

_____

Prior Participation in Warrior Games: ☐ No ☐ Yes: *(list years)*

Prior Classification(s): _____

Next of Kin Contact Information: ☐ Spouse ☐ Mother ☐ Father ☐ Sibling

☐ Other: _____

Name: _____Telephone: (___) _____-_____

CLASSIFICATION DATE: ____/____/201__

Classifier 1 Name: _____Title: ☐ MD ☐ DO ☐ PT ☐ OT ☐ BM
(Last, First)

Classifier 1 Name: _____Title: ☐ MD ☐ DO ☐ PT ☐ OT ☐ BM
(Last, First)

Recorder Name: _____ Title: _____
(Last, First)

ATHLETE REGISTERED SPORTING EVENTS

COMPETING	SPORTING EVENT	Classifier Observation (if applicable) and Comments	Athlete Specific Sport Final Classification *filled in by team classification POC
☐ Yes ☐ No	ARCHERY	☐ Yes ☐ No Comments:	
☐ Yes ☐ No	CYCLING	☐ Yes ☐ No Comments:	
☐ Yes ☐ No	SHOOTING	☐ Yes ☐ No Comments:	
☐ Yes ☐ No	SITTING VOLLEYBALL	☐ Yes ☐ No Comments:	
☐ Yes ☐ No	SWIMMING	☐ Yes ☐ No Comments:	
☐ Yes ☐ No	TRACK	☐ Yes ☐ No Comments:	
☐ Yes ☐ No	FIELD	☐ Yes ☐ No Comments:	
☐ Yes ☐ No	WHEELCHAIR BASKETBALL	☐ Yes ☐ No Comments:	

***this page should be the front page; attach subsequent pages**

Athlete Last Name: _____ First Name: _____ MI: ____

DISABILITY/INJURY/ILLNESS

1. DESCRIPTION OF DISABILITY

When did the Injury/Illness occur? _____(year)

Is the Injury/Illness Permanent? ☐ **Yes** ☐ **No**

How did the Injury/Illness happen? _____

Progress since Injury/Illness**:** ☐ **Unchanged** ☐ **Improvement** ☐ **Worse**

Additional Information: _____

_____

2. AMPUTATION(s) DESCRIPTION

Amputation Anatomical Site	**Amputation Site**	**Residual Limb Length**
Hand	☐ Right ☐Left ☐Bilateral	**cm(s)**
Arm: Above the Elbow	☐ Right ☐Left ☐Bilateral	**cm(s)**
Arm: Below the Elbow		
Foot	☐ Right ☐Left ☐Bilateral	**cm(s)**
Leg: Below the Knee (BKA)	☐ Right ☐Left ☐Bilateral	**cm(s)**
Leg: Above the Knee (AKA)	☐ Right ☐Left ☐Bilateral	**cm(s)**
Arm & Leg (Opposing side)	☐ **Yes** ☐ **No**	**cm(s)**
Arm & Leg (Same side)	☐ **Yes** ☐ **No**	**cm(s)**
Amputations in 3 limbs	☐ **Yes** ☐ **No**	**cm(s)**
Amputations in 4 limbs	☐ **Yes** ☐ **No**	**cm(s)**

3. SPINAL CORD INJURY OR DISABILITY

ANATOMICAL LOCATION OF SPINAL CORD INJURY	**DEGREE OF INJURY**
Cervical Spine at C _____	☐COMPLETE ☐ **INCOMPLETE** ***(describe residual function)***
Thoracic Spine at T _____	☐COMPLETE ☐ **INCOMPLETE** ***(describe residual function)***
Lumbar Spine at L _____	☐COMPLETE ☐ **INCOMPLETE** ***(describe residual function)***
Sacral Spine at S _____	☐COMPLETE ☐ **INCOMPLETE** ***(describe residual function)***

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

4. TRAUMATIC BRAIN INJURY (TBI): COGNITIVE FUNCTIONING TESTING

COMMANDS FOLLOWED	ATHLETE SCORE
Follows Complex Commands (Normal)	☐ Yes ☐ No
Follows 3 ONLY Commands (Mildly Impaired)	☐ Yes ☐ No ☐ N/A
Follows 2 ONLY Commands (Moderately Impaired)	☐ Yes ☐ No ☐ N/A
Follows 1 ONLY Command or less (Severely Impaired)	☐ Yes ☐ No ☐ N/A

5. VISUAL IMPAIRMENT (Athlete must submit documentation supporting VI)

Total Blindness	☐ Both Eyes ☐ Right Eye ☐ Left Eye
Partial Blindness	☐ Both Eyes ☐ Right Eye ☐ Left Eye
Describe Residual Eyesight if applicable:	

6. MOBILITY

Ambulatory without assistance/aids: ☐ Yes ☐ No
Ambulatory *only with the use* of Prosthetics/Crutches/Cane/Walker: ☐ Yes ☐ No
***NON-Ambulatory* and must use wheelchair: ☐ Yes ☐ No**

7. TRUNK IMPAIRMENTS

Please complete the tables below if the athlete has a Spinal Cord Injury or athletes with trunk impairments

TRUNK MUSCLE ACTIVITY	Side	Absent or None (0)	Trace (1)	Poor (2)	Some (3)	Good (4)	All (5)
Upper Abs	Right						
	Left						
Lower Abs	Right						
	Left						
Trunk rotation	Right						
	Left						
Trunk Side flexion	Right						
	Left						
Entire Trunk flexion							
Entire Trunk Extension							
Upper Thoracic extension							

Additional Comments:

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

8. COMPLETE FUNCTIONAL TESTS

8.1 **Complete functional testing is required of all athletes** with the exception of those who:

8.1.1 Are in an **Open** Classification

8.1.2 Have **Uncomplicated Amputations**

8.1.3 Have **Spinal Cord Injuries**

8.2 **Passive Range of Motion (PROM):**

8.2.1 **Passive Range of Motion (PROM) Scoring Scale**

PROM Score	Score Definition
0	No Joint Mobility
1	Slight Mobility: Deficit of 91-99%
2	Deficit of 75-90**%** of normal range
3	Deficit of 50-74% of normal range
4	Deficit of 25-49% of normal range
5	Functional Range of Movement (0-24% deficit)

8.2.2 **PROM Scoring Matrix: Upper Extremities**

UPPER EXTREMITIES							
	NORMAL Range	**RIGHT Range**	**LEFT Range**	**RIGHT % of Deficit**	**RIGHT Number Score**	**LEFT % of Deficit**	**LEFT Number Score**
SHOULDER							
Extension (backward)	**50 degrees**						
Flexion (forward)	**180 degrees**						
Flexion (forward)	**180 degrees**						
Extension (horizontal) or External Rotation	**45 degrees**						
Flexion (horizontal) or External Rotation	**130 degrees**						
Abduction	**180 degrees**						
ELBOW							
Extension	**Zero Degrees**						
Flexion	**150 degrees**						
WRIST							
Flexion	**90 degrees**						
Extension	**70 degrees**						

Additional Comments:

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

8.2.3 **PROM Scoring Matrix: Lower Extremities**

LOWER EXTREMITIES							
	NORMAL Range	RIGHT Range	LEFT Range	RIGHT % of Deficit	RIGHT Number Score	LEFT % of Deficit	LEFT Number Score
HIP							
Flexion	120 Degrees						
Extension Measurement: *20 to 20 degrees*	20 Degrees						
External Rotation	45 Degrees						
Internal Rotation	40 Degrees						
Abduction	45 Degrees						
Adduction	30 Degrees						
KNEE							
Flexion	135 Degrees						
Extension	Zero Degrees						
ANKLE							
DORSI/PLANTAR	10-25 Degrees						

Additional Comments:

8.3 **Impaired Muscle Activity Testing (IMT):**

8.3.1 **Impaired Muscle Activity Testing (IMT) Scoring Scale**:

IMT Score	Score Definition
0	No Muscle Activity (absence of muscle activity)
1	Trace muscle activity but no movement of the limb
2	Active movement with gravity eliminated (some movement against gravity may be possible, but not full range)
3	Active movement through available ROM against gravity ***but no resistance***
4	Active movement through available ROM, against gravity ***plus some resistance***
5	Normal muscle power through the available ROM

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

8.3.2 **Impaired Muscle Activity Testing (IMT): Upper Extremities:**

0	1	2	3	4	5	***Upper Extremity*** **Anatomical Location**	0	1	2	3	4	5
RIGHT							**LEFT**					
						SHOULDER Flexion						
						SHOULDER Extension						
						SHOULDER Abduction						
						SHOULDER Adduction						
						SHOULDER External Rotation						
						SHOULDER Internal Rotation						
						ELBOW Flexion						
						ELBOW Extension						
						ELBOW Pronation						
						ELBOW Supination						
						WRIST Flexion						
						WRIST Extension						

Additional Comments:

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

8.3.3 **Impaired Muscle Activity Testing (IMT): Lower Extremities:**

0	1	2	3	4	5	***Lower Extremity*** **Anatomical Location**	0	1	2	3	4	5
RIGHT							**LEFT**					
						HIP Flexion						
						HIP Extension						
						HIP Abduction						
						Hip Adduction						
						HIP External Rotation						
						HIP Internal Rotation						
						KNEE Flexion						
						KNEE Extension						
						ANKLE Dorsiflexion						
						ANKLE Plantar Flexion						
						ANKLE Pronation						
						ANKLE Supination						

Additional Classifier Comments:

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

8.4. **Balance Testing:**

8.3.2 **Balance Testing and Scoring Scale:**

Balance Score	Balance Score Definition
0	No Muscle Activity (absence of muscle activity)
1	Trace Ability to Maintain Balance
2	Poor Balance: Unable to maintain balance against gravity
3	Fair Balance: Unable to maintain balance with applied resistance
4	Good Balance: Able to hold balance against moderate assistance with slight imbalance
5	Normal Balance

8.4.2 **Sitting Balance Testing Matrix:**

0	1	2	3	4	5	*Sitting Balance Testing*	0	1	2	3	4	5
RIGHT							LEFT					
						Lateral Trunk Test						
						Extension Trunk Test						
						Flexion Trunk Test						
						Superman Test						

Additional Classifier Comments:

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

8.4.3 **Standing Balance Testing Matrix:**

**See supplemental Classifier Packet for comprehensive information.*

0	1	2	3	4	5	***Standing Balance Testing***	0	1	2	3	4	5
RIGHT							**LEFT**					
						Tight Rope Walking						
						Single Leg Stand						
						Single Leg Hops						
						Side Steps						
						Grapevine						
						High Steps						
						Butt Kicks						

Additional Classifier Comments

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

Vision Evaluation and Medical Diagnostics Form

This form is to be completed by a registered and licensed ophthalmologist/optometrist. All medical documentation required on pages I-10 and I-11 needs to be attached. The form and the attached medical documentation may not be older than 12 months at the time of the Athlete Evaluation.

Athlete Information

Service Branch: _____ **Date of Birth:** ___/___/_____ **Gender:** ☐ Female ☐ Male

Name (Last name, First): _____

Sports (competing in):

☐ Archery ☐ Shooting ☐ Cycling ☐ Swimming ☐ Track & Field
☐ Sitting Volleyball ☐ Wheelchair Basketball

Medical History:

Age of onset: _____; Anticipated future procedure(s): ☐ Yes ☐ No

Athlete wears glasses	☐ Yes ☐ No	**Correction: Right:** _____/20 **Left:** _____/20 **Both Eyes:** _____/20
Athlete wears contact lenses:	☐ Yes ☐ No	**Correction: Right:** _____/20 **Left:** _____/20 **Both Eyes:** _____/20
Athlete wears eye prosthesis	☐ Yes ☐ No	☐ Right ☐ Left

Assessment of Visual Acuity and Visual Fields:

Visual Acuity: _____

_____

Visual Acuity	Right eye	Left eye
Assessment With Correction		
Assessment Without Correction		

Visual Acuity Comments: _____

_____

Visual Fields	Right eye	Left eye
	_____**In degrees (radius)**	_____**In degrees (radius)**

Visual Fields Comments: _____

_____

Type of correction: _____

Measurement Method: _____

Athlete Last Name: _____ **First Name:** _____ **MI:** ____

Attachments to the Medical Diagnostic Form

1. **Visual Field Test:**
   For all athletes with a restricted visual field a visual field test must be attached to this form. The athlete's visual field must be tested by full-field test (120 degrees) and a 30 degrees, 24 degrees or 10 degrees central field test, depending on the pathology. One of the following perimeters should be used for the assessment: Goldmann Perimetry (Intensity III/4), Humphrey Field Analyzer or Octopus (Interzeag).

2. **Additional medical documentation:**

Please specify which eye condition the athlete is affected by.

Eye condition	Additional medical documentation required (see below)
U Anterior disease	none
U Macular disease	• Macular OCT • Multifocal and/or pattern ERG* • VEP* • Pattern appearance VEP*
U Peripheral retina disease	• Full field ERG* • Pattern ERG*
U Optic Nerve disease	• OCT • Pattern ERG* • Pattern VEP* • Pattern appearance VEP*
U Cortical / Neurological disease	• Pattern VEP* • Pattern ERG* • Pattern appearance VEP*