BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

CALIFORNIA STATE ATHLETIC COMMISSION
2005 Evergreen Street, Suite 2010 | Sacramento, California 95815
Phone: (916) 263-2195 Fax: (916) 263-2197
Website: www.dca.ca.gov/csac Email:CSAC@dca.ca.gov

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 csac@dca.ca.gov OR FAX TO (916) 263-2197.

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 California?
☐ **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)

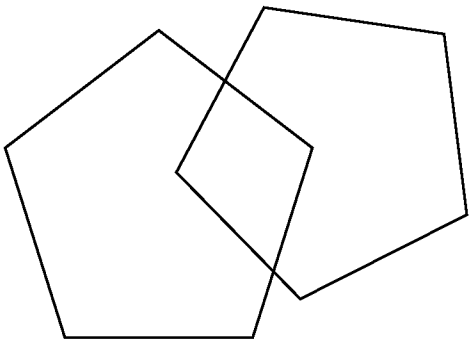
20. List any other symptoms or evidence of neurological abnormalities from history or observations.

_____ **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 NEUROLOGIST OR NEUROSURGEON

o As a licensed physician specializing in **neurology or neurosurgery** *(circle one)*, I confirm that I examined this **applicant in person, and I DO or DO NOT** *(circle one)* believe that this applicant could be permitted to be licensed in California.

Is further referral necessary? _____

Are additional exams needed? _____

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

_____ _____
Licensed Neurosurgeon or Neurologist's Name (Print) Medical License Number

_____ _____
Signature of Neurosurgeon or Neurologist Date

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

The athlete is required to sign the authorization and acknowledgement below in either English or Spanish. The California State Athletic Commission is a public health authority, as defined in 45 CFR 164.501, exempt from HIPAA, and is authorized by Business and Professions Code Section 18600, et seq to collect information about the applicant's physical condition. Authority to provide the Athletic Commission with information requested on this examination is established pursuant to Section 18640, 18642, 18643, 18660, and 18711 of the California Business and Professions Code. All information is mandatory for licensure. Failure to provide this mandatory information will result in denial of a license.

NEUROLOGICAL EXAMINATION ACKNOWLEDGEMENT

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

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 California State 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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