The Diving Medical Advisory Committee

DMAC, Eighth Floor, 52 Grosvenor Gardens, London SW1W 0AU, UK
Tel: +44 (0) 20 7824 5520

www.dmac-diving.org
info@dmac-diving.org

Aide Mémoire for Recording and Transmission of Medical Data to Shore

DMAC 01 Rev. 1 – July 2015

Supersedes DMAC 01, which is now withdrawn

C O N F I D E N T I A L

You are not necessarily expected to fill in every page for every patient.

This form has been designed in three parts to make it easier to use.

Part 1 is an aide mémoire to obtain the **initial essential information** for transmission ashore in event of a medical emergency. This information will enable the onshore doctor to advise on immediate management of the casualty.

Part 2 collects more detailed information to provide a permanent record of the incident and to assist in accident analysis. Obviously, in urgent cases **there must be no delay** in contacting medical assistance with the information in Part 1. Part 2 should and can be completed later.

The onshore doctor will frequently ask for some further examination(s) to be carried out.

Part 3 provides a form for recording this information. This part will need to be used initially for the first examination and **may need to be used repetitively at the request of the onshore doctor**.

This part will be a record of your findings at any given time point. There is space to record which time point this is and to be clear regarding date and time and before or after which treatment. This is important in order to be able to get a decent time line on the treatment and progression of each case.

In all parts of this form there are sections which will not be relevant for the type of diving and situation you are in. It is recognised that it will not be necessary to complete the form fully in most cases. **You are not necessarily expected to fill in every page for every patient**.

Where a question (or section) is not applicable, 'N/A' should be entered.

If you are uncertain of the meaning of a question, do not attempt to answer it, but ring the question number, and annotate accordingly.

It is particularly useful to attempt to get photos by whatever means possible, for any unusual occurrence and to forward these on to the Doctors involved in supporting you.

For consistency, please use local time throughout.

This form can also be completed 'electronically'. Instructions for annotating the diagrams can be found at www.dmac-diving.org/guidance/DMAC01-instructions.pdf – ***please ensure that you are able to save your file before completing it***.

A check should be made regarding any local data protection legislation as this could impact on the transmission of personal information.

Initial Essential Information for Transmission Ashore In Event of an Emergency

Part 1 – Section A: **General Information**

1.	**Patient Family name:**		**First name:**	
	Age:		**Date of birth** (dd/mm/yyyy)**:**	
2.	**Company:**			
3.	**Worksite/vessel:**			
4.	**Country and/or location:**			
5.	**Date of onset of incident:**		**Local time** (HH:MM)**:**	
6.	**Type of incident:** A) Surface supplied ☐ i) Potentially DCI related ☐ ii) Trauma related ☐ iii) Other (e.g. possible myocardial infarction) ☐ B) Saturation ☐			
7.	**Reason for contacting shore doctor:** Assistance required urgently (life threatening) ☐ Assistance required as soon as possible ☐ Assistance required when practicable ☐ Assistance required when patient gets ashore ☐ For information only ☐			
8.	**State of consciousness:** Fully alert and orientated ☐ Drowsy (tends to fall asleep) ☐ Confused ☐ Unconscious but responds to pain ☐ Unconscious and unresponsive to pain ☐			
9.	**Has there been any disease and/or treatment since the last medical certificate for fitness to dive was issued:** Yes ☐ No ☐			
10.	**Specifically detail any significant past or recent medical history. Please identify any medication taken recently and ask for allergies:**			

Note: Cumulative hyperbaric exposure is a relevant parameter for assessing the level of individual susceptibility to DCI. Copies of the diver's logbook will show numbers of surface supplied dives – number of days spent in saturation – number of variations in storage depths – number of saturation excursions. A copy of the last medical certificate for fitness to dive and a copy of the last pre-saturation medical examination should be provided.

Part 1 – Section B: **Information about the Dive related to the Incident**

(If the illness is not related to diving, skip to Section E)

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	

1. Method:

SCUBA – open circuit	☐	Wet bell	☐
SCUBA – semi-closed circuit	☐	Bell bounce	☐
SCUBA – closed circuit	☐	Saturation	☐
Surface supplied	☐		

2. Breathing gas:

Air mixture	☐	Nitrox	☐
Heliox	☐	Trimix	☐

3. Job:

Diver	☐	
Bellman	☐	
Other (specify):	☐	_____

4. Working depth: _____ metres ☐/feet ☐

5. Bell depth (where relevant)**:** _____ metres ☐/feet ☐

6. Storage depth (where relevant)**:** _____ metres ☐/feet ☐

7. Time spent at working depth: _____ minutes

8. Decompression table and method selected: _____

In-water	☐	Nitrox	☐

If surface decompression, indicate the duration of the surface interval _____ minutes

Depth selected: _____ metres ☐/feet ☐

Bottom time selected: _____ minutes

Surface interval selected (repetitive dives): _____ hours _____ minutes

9. Type of work performed during the last working dive:

_____

_____

_____

Workload intensity during the dive (to be assessed by diver and supervisor)**:**

Low ☐ Fair ☐ High ☐ Very high ☐

10. Adverse conditions, if any (e.g. sea state, tidal stream, temperature, fouling, disorderly ascent, hard work, etc.)**:**

_____

_____

11. Did the incident begin:

In the water	☐	In the deck chamber	☐
In the bell	☐		
Other (specify):	☐	_____	

12. At the onset of symptoms, was the patient:

Descending (ambient pressure increasing)	☐	Ascending (ambient pressure decreasing)	☐
On the bottom	☐	On the surface	☐
Undergoing no pressure change	☐	In the DDC	☐

Part 1 – Section C: **Compression/Decompression Incident**

(If the illness is not related to diving, skip to Section E)

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	

1.	**The incident occurred during or immediately following compression:**	Yes ☐	No ☐
2.	**The incident occurred during normal decompression:**	Yes ☐	No ☐
3.	**The incident occurred after surfacing following normal decompression:**	Yes ☐	No ☐
	Time of end of decompression at:	____ hours	____ minutes
4.	**The incident occurred following excursion from saturation:**	Yes ☐	No ☐
	Was this an upward or downwards excursion:	Up ☐	Down ☐
	Time of onset after <u>return</u> to storage depth:	____ hours	____ minutes
5.	**The incident occurred following blow-up/drop in pressure:**	Yes ☐	No ☐
	From: Depth: ____ metres ☐/feet ☐ Local time (HH:MM):		
	To: Depth: ____ metres ☐/feet ☐ Local time (HH:MM):		
6.	**The incident occurred in other circumstances:**	Yes ☐	No ☐
	Specify: ____		
7.	**How many divers are in the chamber with the affected diver:** _________		
8.	**How many of these divers have the DMT qualification:** _________		
9.	**Onset of first symptom at:**		
	Depth: ____ metres ☐/feet ☐ Local time (HH:MM):		
10.	**Niggles** (minor aches or itchings, often transient)**:**	Yes ☐	No ☐
11.	**Pain in joints:**	Yes ☐	No ☐
	State location: ____		
12.	**Pain in muscles:**	Yes ☐	No ☐
	State location: ____		
13.	**Pins and needles** (paraesthesia, tingling)**:**	Yes ☐	No ☐
	State location: ____		
14.	**Patches of numbness, or altered sensation:**	Yes ☐	No ☐
	State location: ____		
15.	**Muscle weakness or total loss of power** (paralysis)**:**	Yes ☐	No ☐
	State location: ____		
16.	**Difficulty in urinating:**	Yes ☐	No ☐
17.	**Pain in the lumbar region, around waist, or in the abdomen:**	Yes ☐	No ☐

Part 1 – Section C: **Compression/Decompression Incident** (continued)

(If the illness is not related to diving, skip to Section E)

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	

18.	**Standing upright is difficult or impossible:**		Yes ☐	No ☐
19.	**Nausea:**		Yes ☐	No ☐
20.	**Vomiting:**		Yes ☐	No ☐
21.	**Vertigo, loss of balance** (dizziness, often with a sense of rotation of either themselves or their surroundings)**:**		Yes ☐	No ☐
22.	**Affected hearing:**		Yes ☐	No ☐
	If yes which side	Both ☐	Right ☐	Left ☐
23.	**Speech problems:**		Yes ☐	No ☐
24.	**Visual problems** (visual acuity, blurred vision, affected field of vision)**:**		Yes ☐	No ☐
	If yes which side	Both ☐	Right ☐	Left ☐
25.	**Drowsiness:**		Yes ☐	No ☐
	Specify: _____			
26.	**Agitation:**		Yes ☐	No ☐
	Specify: _____			
27.	**Breathlessness, painful breathing:**		Yes ☐	No ☐
	Specify: _____			
28.	**Respiratory distress worsening with decompression:**		Yes ☐	No ☐
29.	**Blood-stained froth in or coming from the airways:**		Yes ☐	No ☐
30.	**Skin: Pruritus** (itching) **with or without a marbling or erythematous rash:**		Yes ☐	No ☐
31.	**Sensation of swollen and/or painful skin in any area with or without rash:**		Yes ☐	No ☐
32.	**Others** (please specify any symptoms and their time of appearance and development below)**:**		Yes ☐	No ☐

It is particularly useful to attempt to get photos by whatever means possible, for any unusual occurrence and to forward these on to the doctors involved in supporting you.

Part 1 – Section D: **Previous Dive**

(If ended less than 24 hours before the accident)

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	

1. Method:

SCUBA – open circuit	☐	Wet bell	☐
SCUBA – semi-closed circuit	☐	Bell bounce	☐
SCUBA – closed circuit	☐	Saturation	☐
Surface supplied	☐		

2. Breathing gas:

Air mixture	☐	Nitrox	☐
Heliox	☐	Trimix	☐

3. Depth: _____ metres ☐ / feet ☐

4. Bottom time (where relevant)**:** _____ minutes

5. Decompression table and method selected: _____

In-water	☐	Nitrox	☐

If surface decompression, indicate the duration of the surface interval _____ minutes

Depth selected: _____ metres ☐ / feet ☐

Bottom time selected: _____ minutes

Surface interval selected (repetitive dives): _____ hours _____ minutes

6. Normal decompression: Yes ☐ No ☐

7. End of decompression:

Date (dd/mm/yyyy) | Local time (HH:MM):

8. If saturation, when back to storage depth from last working dive:

Date (dd/mm/yyyy) | Local time (HH:MM):

9. Type of work performed during last working dive:

_____

10. Workload intensity during the dive (to be assessed by diver and supervisor)**:**

Low ☐ Fair ☐ High ☐ Very high ☐

11. What type of activity does he/she do between dives:

_____

Part 1 – Section E: **Accident or Illness not related to Decompression**

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	

1.	**Nature of accident or illness:**		
2.	**Does he/she have difficulty or pain with breathing:**	Yes ☐	No ☐
3.	**Is the diver obviously injured:** Describe:	Yes ☐	No ☐
4.	**Is he/she bleeding:**	Yes ☐	No ☐
5.	**If yes, is bleeding controlled:**	Yes ☐	No ☐
6.	**State of consciousness:** Fully alert and orientated ☐ Drowsy (tends to fall asleep) ☐ Confused ☐ Unconscious but responds to pain ☐ Unconscious and unresponsive to pain ☐		
7.	**Details of symptoms:**		
8.	**Treatment given:**		

Additional Information for Record Purposes

*NB. Do **not** delay transmission of Part 1 in order to complete this part of the form*

Part 2 – Section A: **General Information**

(Some of this may be repetitive from Part 1 Section A, but can be completed in greater detail)

1.	**Patient Family name:**		**First name:**	
2.	**Age:**		**Date of birth** (dd/mm/yyyy)**:**	
	Height (metres)**:**		**Weight** (kilos)**:**	
	Smoker:		Yes ☐	No ☐
3.	**Date of last medical examination** (dd/mm/yyyy)**:**			
4.	**Where are the medical records held:**			
5.	**Details of main medical carer, including address** (be it a GP or other)**:** E-mail address: Phone number:			
6.	**Details of any previous or possible decompression sickness:**			
7.	**Has there been any disease and/or treatment since the last medical certificate for fitness to dive was issued:**		Yes ☐	No ☐
8.	**Specifically detail any significant past or recent medical history. Please identify any medication taken recently and ask for allergies:**			
9.	**Have there been any specific activities or travel during the previous two months:**		Yes ☐	No ☐
10.	**Name of diving supervisor:** E-mail address: Phone number:			
11.	**Name of medical attendant:** E-mail address: Phone number:			
12.	**Local time** (HH:MM) **of transmission of Part 1:**		**Date** (dd/mm/yyyy)**:**	
13.	**Addressee:**			
14.	**Copied to:**			

Part 2 – Section B: **Brief Statement of the Problem**

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	

Part 2 – Section C: **Summary of Advice/Instructions Received from Ashore**

Part 2 – Section D: **Details of Treatment Given**

(Including therapeutic tables by number as well as depth, duration and gases, and all supplementary therapy). State also times of implementation

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	

Part 2 – Section E: **Record of Progress; Summary of History of the Condition, Times of Significant Changes**

(Please use this alongside the use of Part 3 as needed)

Part 2 – Section F: **Summary of Facilities and Equipment Available**

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	

Record of Medical Examination

(This part may be used repeatedly)

All or part of this examination may be carried out at the request of the onshore doctor. Results should be recorded in the appropriate section and the questions which are not relevant to the particular incident should be left blank.

Part 3 – Section A: **Examination/General**

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	
Country and/or location:			

Time point (please complete date (dd/mm/yyyy) and local time (HH:MM))**:**		
Initial examination:	Date	Time
Pre- or post-therapy:	Pre ☐	Post ☐
This examination:	Date	Time
Therapy number:		
Examination number:		
Name of person examining:		

1. **Is the patient in pain:** Yes ☐ No ☐

If 'yes', specify site, intensity and any factors which worsen or relieve it:

Pain score. Visual analogue scale (0 being no pain, 10 being the worst pain imaginable)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

2. **Does he/she have any major injury:** Yes ☐ No ☐

If 'yes', name the site and describe briefly. If there is bleeding give an estimate of blood loss (if yes, please attempt to take a photo of the affected area and send to the doctor):

3. **What is his/her temperature:** ____ °C

How and where was this temperature taken: ____

If he/she has just come out of the water, what is the water temperature: ____ °C

What is the ambient temperature: ____ °C

4. **Does he/she have any skin rashes** (undress the patient to his/her underwear)**:** Yes ☐ No ☐

If 'yes', describe appearance and site (if yes, please attempt to take a photo of the affected area and send to the doctor):

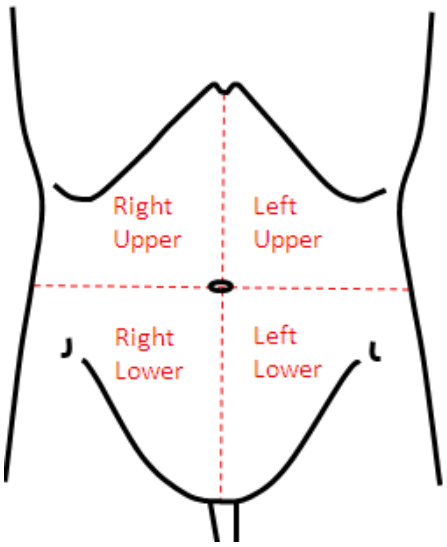
Part 3 – Section B: **Cardiorespiratory Systems**

Family name:		**First name:**		**Date of birth:**	
Exam number:		**Time:**		**Date:**	
Country and/or location:					

1.	**Is his/her colour** (look at lips and nail beds)**:**	Normal ☐	Pale ☐	Cyanosed (blue) ☐	
2.	**Is he/she visibly sweating:**			Yes ☐	No ☐
3.	**What is his/her:** i) Pulse (count for 30 seconds, then x 2)				_ _ _ _ per min
	Is the pulse regular:			Yes ☐	No ☐
	ii) Blood pressure			_ _ _ _ Syst	_ _ _ _ Diast
	iii) Respiratory rate (count for 30 seconds, then x 2)				_ _ _ _ per min
	iv) Pulse oximetry				_ _ _ _ %
	v) Measure the capillary refill time (use your thumb to press down the nail on the patient's index finger for 5-10 seconds. Release the pressure – how long does it take to get normal nail bed colour back?)				_ _ _ _ seconds
4.	**Does he/she have pain or difficulty breathing:**			Yes ☐	No ☐
	If 'yes', describe:				
5.	**Does he/she have a cough:**			Yes ☐	No ☐
	If 'yes', has he/she coughed blood:			Yes ☐	No ☐
6.	**Is he/she short of breath:**			Yes ☐	No ☐
	If 'yes', has this been affected by:				
	i) increase of pressure			Yes ☐	No ☐
	ii) decrease of pressure			Yes ☐	No ☐
7.	**Is the trachea** (windpipe) **central** (i.e. normal)**:**			Yes ☐	No ☐
8.	**Are breath sounds audible equally on both sides of the chest** (listen at three different levels – preferably over the back)**:**			Yes ☐	No ☐
9.	**Is there any subcutaneous emphysema** (crackling sensation in the tissues around the thorax) (carefully feel in each triangular area between the shoulder and the neck)			Yes ☐	No ☐

Part 3 – Section C: **Abdomen**

Family name:		**First name:**		**Date of birth:**	
Exam number:		**Time:**		**Date:**	
Country and/or location:					

1.	**Does the patient have abdominal pain:**	Yes ☐	No ☐
	If 'yes', specify site by writing on the chart, and make a note of the character:		
			
	When examining points 2-4, gently touch (palpate) **the abdomen in each of the four quadrants**		
2.	**Does it feel soft:**	Yes ☐	No ☐
	If 'no', specify the site (by writing 2 on the chart above, over the appropriate area)		
3.	**Are there any swellings:**	Yes ☐	No ☐
	If 'yes', specify site (by writing 3 on the chart above, over the appropriate area), size and consistency:		
4.	**Is the abdomen tender:**	Yes ☐	No ☐
	If 'yes', specify the site (by writing 4 on the chart above, over the appropriate area; assess tenderness by slowly depressing and then abruptly removing pressure in each quadrant)		
5.	**Can you hear bowel sounds with a stethoscope used for one minute:**	Yes ☐	No ☐
6.	**Does the patient have diarrhoea:**	Yes ☐	No ☐
	If 'yes', specify: a) When the patient last opened his/her bowels b) Specify the frequency in the last 24 hours		
7.	**Has the patient vomited:**	Yes ☐	No ☐
	If 'yes', specify: a) When the patient last vomited b) If he/she is still vomiting, specify frequency and character:		

Part 3 – Section C: **Abdomen** (continued)

Family name:		**First name:**		**Date of birth:**	
Exam number:		**Time:**		**Date:**	
Country and/or location:					

8.	**Has he/she vomited blood:**	Yes ☐	No ☐
9.	**Can the patient pass urine without difficulty:**	Yes ☐	No ☐
	When did the patient last pass urine		
10.	**Is urinating painful:**	Yes ☐	No ☐
11.	**Is the urine** Clear ☐ Blood-stained (red) ☐ Other (explain) ☐ _____		
12.	**Urine colour** (tick applicable reference colour)**:** ☐ ☐ ☐ ☐ ☐ ☐ Unable to provide ☐		
13.	Urine dip stick results (when reading results from the side of a bottle check order of results – they are usually, but not always, in order given below): Leukocytes — Positive ☐ Negative ☐ Nitrite — Positive ☐ Negative ☐ Urobilinogen — Positive ☐ Negative ☐ Protein — Positive ☐ Negative ☐ pH — Positive ☐ Negative ☐ Haemoglobin — Positive ☐ Negative ☐ Specific gravity — Positive ☐ Negative ☐ Ketone — Positive ☐ Negative ☐ Bilirubin — Positive ☐ Negative ☐ Glucose — Positive ☐ Negative ☐ Record in more detail any positive results (semi-quantitative values are usually reported as: trace, 1+, 2+, 3+ and 4+):		
14.	**Additional comments**		

Part 3 – Section D: **Nervous System**

(This may be the most frequently repeated of the examinations, and this section may need to be used and transmitted several times)

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	
Country and/or location:			

Time point (please complete date (dd/mm/yyyy) and local time (HH:MM))**:**		
Initial examination:	Date	Time
Pre- or post-therapy:	Pre ☐	Post ☐
This examination:	Date	Time
Therapy number:		
Examination number:		
Name of person examining:		

1.	**Has he/she had any visual disturbance:** Yes ☐ No ☐ If 'yes', specify: _____	
2.	**Has he/she had a headache:** Yes ☐ No ☐ If 'yes', specify the location and timing of this headache: _____	
	Headache pain intensity score. Visual analogue scale (0 being no pain, 10 being the worst pain imaginable) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐	
3.	**State of consciousness:** Fully alert and orientated ☐ Drowsy (tends to fall asleep) ☐ Confused ☐ Unconscious but responds to pain ☐ Unconscious and unresponsive to pain ☐	
4.	**Are his/her pupils equal and reactive to light:** Yes ☐ No ☐ Quickly point a flashlight beam into the right pupil. Does it contract? Repeat the test. Does the opposite pupil contract similarly? Repeat examination on the left eye in a similar fashion. If 'no', specify: _____	
5.	**Does the patient have vertigo** (dizziness, often with a sense of rotation of either themselves or their surroundings)**:** Yes ☐ No ☐	
6.	**Does the patient have normal vision:** Yes ☐ No ☐ Put your index finger approx. arm's length in front of the patient's nose. Ask the patient to focus on it. Can he/she see it sharply: Yes ☐ No ☐ Does he/she have double vision: Yes ☐ No ☐	

Family name:		**First name:**		**Date of birth:**	
Exam number:		**Time:**		**Date:**	
Country and/or location:					

7. **Does the patient have nystagmus** (eye flickering)**:** Yes ☐ No ☐

Put your index finger approx. arm's length in front of the patient's nose. Ask the patient to focus on it.
Slowly move your finger in an 'H' pattern. Is there any nystagmus (uncontrolled oscillatory or jerky eye movements)? Particularly look for this when the patient is gazing almost at the extreme of eye movement.
You may be able to get a video of this movement and send it to the onshore doctor.

8. **Is hearing equal and normal in both ears:** Yes ☐ No ☐

Stand behind the patient or ask him to close his/her eyes. Slide/rub your fingers against each other outside his/her right ear.
Ask him to tell you when he/she can hear it. Repeat the examination on the left ear. Is there any difference?
Alternatively: Put the patient 2-3 m in front of you with his/her back against you. Ask him to cover his/her right ear.
Whisper two-digit numbers (21-99) and ask him to repeat it. Redo with left ear.
Is there any difference between the two sides?
In a normal diving environment this is likely to be difficult – we are only looking for obvious problems.

9. Are the remainder of the cranial nerves normal:

Are both eye movements equal and normal: Yes ☐ No ☐

Is facial sensation normal (test on three levels on each side): Yes ☐ No ☐

Are facial movements normal on both sides (smile, close and open both eyes shrug his/her upper face and blow out cheeks): Yes ☐ No ☐

Can he/she swallow easily (look for movement of the larynx): Yes ☐ No ☐

Is the soft palate symmetrically positioned in the throat without deviation of the uvula: Yes ☐ No ☐

Can he/she shrug his/her shoulders equally (with and without resistance): Yes ☐ No ☐

Are his/her tongue movements normal (does the tongue deviate when stretched straight forwards and can it move normally?): Yes ☐ No ☐

10. **Can the patient voluntarily move his:**

R Shoulder	Yes ☐	No ☐		L Shoulder	Yes ☐ No ☐
R Elbow	Yes ☐	No ☐		L Elbow	Yes ☐ No ☐
R Wrist	Yes ☐	No ☐		L Wrist	Yes ☐ No ☐
R Fingers	Yes ☐	No ☐		L Fingers	Yes ☐ No ☐
R Hip	Yes ☐	No ☐		L Hip	Yes ☐ No ☐
R Knee	Yes ☐	No ☐		L Knee	Yes ☐ No ☐
R Angle	Yes ☐	No ☐		L Angle	Yes ☐ No ☐
R Toes	Yes ☐	No ☐		L Toes	Yes ☐ No ☐

11. **Has he/she any weakness:** Yes ☐ No ☐

Examine the force that is achievable in each joint listed above.
Wherever possible ask him to contract muscles on both sides against your resistance.
Carefully consider: Is the force equal on the two sides?
Is the force considered normal by yourself and the patient?
Most joints (e.g. wrist, elbow, knee and ankle) have only two directions of movement (one plane) but the hip and shoulder should be assessed for movements in two planes. It is common to be slightly stronger on the dominant (usually right) side.

If 'yes', specify:

Part 3 – Section D: **Nervous System** (continued)

Family name:		**First name:**		**Date of birth:**	
Exam number:		**Time:**		**Date:**	
Country and/or location:					

12.	**Are reflexes** (tendon jerks)**:**		Normal	Increased	Absent	Not clear
	Triceps	R	☐	☐	☐	☐
		L	☐	☐	☐	☐
	Biceps	R	☐	☐	☐	☐
		L	☐	☐	☐	☐
	Knee	R	☐	☐	☐	☐
		L	☐	☐	☐	☐
	Ankle	R	☐	☐	☐	☐
		L	☐	☐	☐	☐
	The reflex examination is only to be completed by trained persons and should not delay other examinations. When assessing reflexes note carefully any difference between the two sides (this is more important than the strength of the reflexes).					
13.	**Is the plantar response:**				↑R ☐	↑L ☐
				OR	↓R ☐	↓L ☐
				or not clear	R ☐	L ☐
	The plantar response is tested by drawing a moderately sharp, but non-injuring object (e.g. the tip of a pen) on outermost part of the sole of the foot from the heel to the fifth toe. Carefully observe the first direction of movement of the first (great) toe.					
14.	**Does he/she feel any altered feelings in the skin** (numbness, pins and needles)**:**				Yes ☐	No ☐
	If 'yes', specify and identify on the diagram on page 19 _____					
15a.	**Is there a normal sensory response to soft touch:**				Yes ☐	No ☐
	If 'no', specify and identify on the diagram on page 19 _____					
	Use a cotton wool or textile to lightly touch the back of his/her right big toe. Repeat on the left side. Is there normal sensation? Is this equal on the two sides? Repeat successively on representative parts of the rest of the body ensuring you touch both outer and inner parts of the legs and arms. It is not necessary to examine skin sensation on the back if you compare right and left side on 5-6 levels on abdomen and thorax					
15b.	**Is there a normal sensory response to pinprick:**				Yes ☐	No ☐
	If 'no', specify and identify on the diagram on page 19					
	Use a toothpick or a similar sharp (but not wounding) object to test for sensation of sharpness. Otherwise do the test as per 15					
16.	**Can you detect a level of sensory change:**				Yes ☐	No ☐
17.	**Does he/she have distal vibration sensation** (using 128Hz tuning fork):				Yes ☐	No ☐
	If 'no', specify: _____					
	Ask him to close his/her eyes. Put the 128Hz tuning fork on the top of the joint of the big toe. It should explained to the patient that it is the sensation of vibration, not cold or touch, which is being tested. The test may be made more objective and sensitive by giving a careful explanation and demonstration of the vibratory sensation. Place the tuning fork on the joint of the big toe, sometimes vibrating and sometimes not. If he/she has absent vibration sensation on the big toe, perform this test again on the lateral malleolus (ankle bone).					

Family name:		**First name:**		**Date of birth:**	
Exam number:		**Time:**		**Date:**	
Country and/or location:					

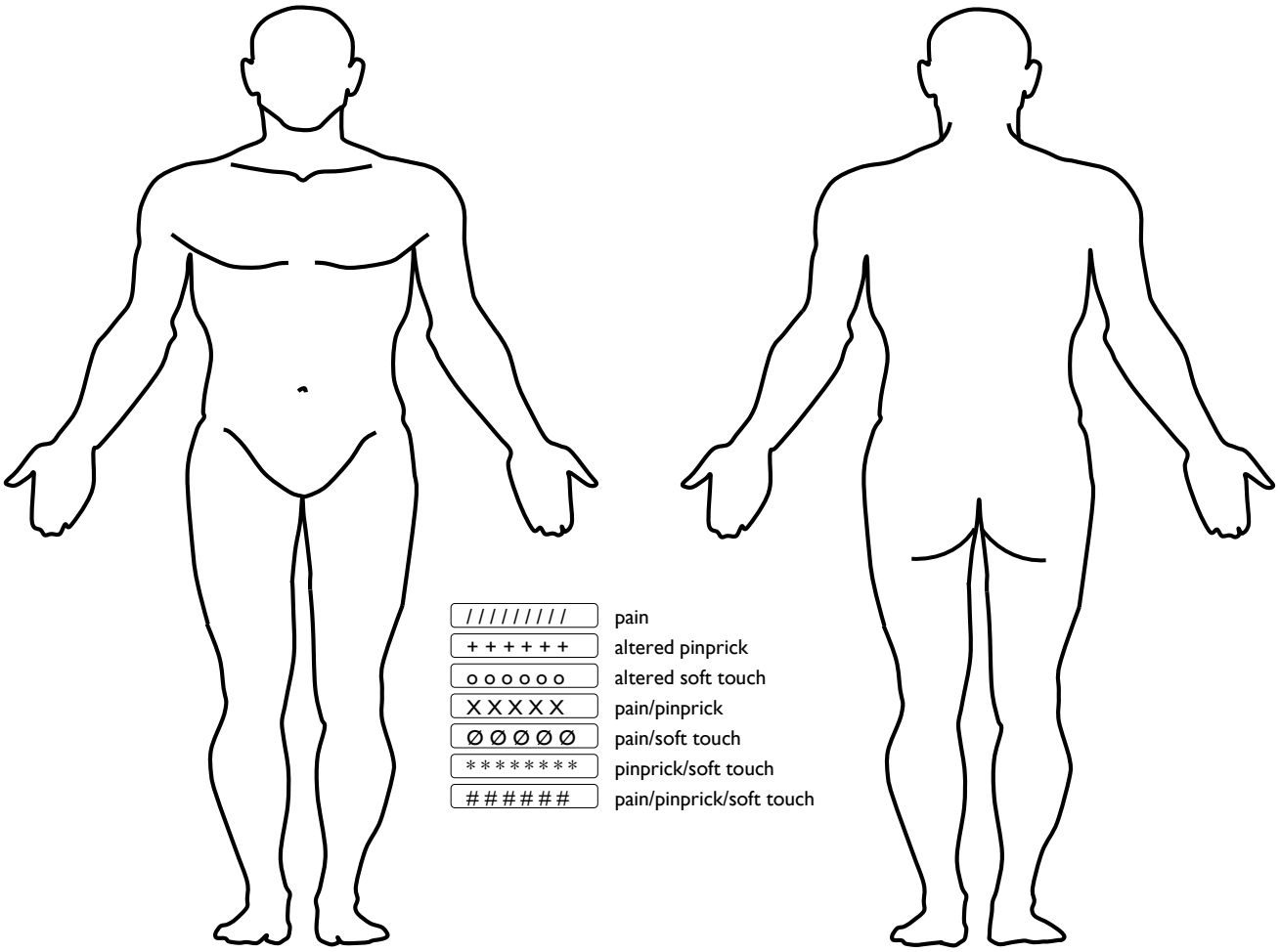
18.	**Does he/she have equal and seemingly normal proprioceptive** (joint position) **sense:** Yes ☐ No ☐ If 'no', specify: Grasp his/her right big toe with one finger on each side (not on sole/back). Ask him to close his/her eyes and keep them closed for this test. Put the toe in the maximum upper position and explain 'This is up'. Then move the toe to the maximum downward position and explain 'This is down'. Then position the toe in the mid/neutral position and ask him to notify the direction of the movement when you slowly move the toe upwards. Repeat the movement in different directions (a few times) to learn his/her threshold for joint movement. Repeat the examination on the left side. Ensure you move the toe more than 10 degrees in arc, with larger movements first, then smaller ones.

Please document your findings on the diagrams below.

Mark areas of altered sensation as shown below. Please note these may change over time with treatment.

Also use this diagram to show any other findings of interest.

If there are visible signs – please remember that photos are very useful.



Family name:		**First name:**		**Date of birth:**	
Exam number:		**Time:**		**Date:**	
Country and/or location:					

19.	**Does he/she have a normal finger–nose test:** Yes ☐ No ☐ This is a useful test of co-ordination in the arms. Stand in front of him and ask him to touch the tip of your index finger held in front of his/her nose, with the index finger of his/her outstretched right arm and then to touch the tip of his/her nose. He should be able to do this repeatedly, both with his/her eyes open and closed. You needed to assess smoothness of movement and accuracy. Repeat the test using his/her left arm. The sensitivity of this test can be increased by the examiner moving his/her finger to a different place whilst the patient's finger is en route to it with his/her eyes open.
20.	**Does he/she have a normal heel–shin test:** Yes ☐ No ☐ This is a useful test of co-ordination in the legs. When he/she is lying flat ask him to place the heel of his/her right foot on the opposite knee and then slide it down accurately, on the shin, to the ankle and back. He should be able to do this with his/her eyes open and closed. You needed to assess smoothness of movement and accuracy. Repeat the test using his/her left foot.
21.	**Can he/she perform a normal tandem gait walk** (heel–toe walking)**:** Yes ☐ No ☐ Ask him to walk heel to toe for about 10 steps both forwards and backwards with his/her eyes open first and then with his/her eyes closed. Be prepared to catch him in case he/she falls.
22.	**Is the Romberg test positive or negative** Positive ☐ Negative ☐ Ask him to remove his/her shoes and stand with his/her two feet together. his/her arms should be held by his/her sides. You should ask him to first stand quietly with eyes open, and then with his/her eyes closed. he/she should try to maintain his/her balance. Be prepared to catch him in case he/she falls. This test is scored by counting the seconds he/she is able to stand with eyes closed. Record seconds he/she is able to stand with eyes closed. Romberg's test is positive if he/she sways significantly or falls while his/her eyes are closed. This test may not be possible to use on a vessel in motion – it should only be performed on a stable and solid 'platform'.
23.	**Is the Sharpened Romberg test positive or negative** Positive ☐ Negative ☐ Test results in seconds: 1st _ _ _ _ _ 2nd _ _ _ _ _ 3rd _ _ _ _ _ 4th _ _ _ _ _ Ask him to remove his/her shoes and stand with his/her feet in a tandem gait (heel–toe) position. his/her arms should be crossed over the chest. You should ask him to first stand quietly with eyes open, and then with his/her eyes closed. he/she should try to maintain his/her balance. Be prepared to catch him in case he/she falls. This test is scored by counting the seconds he/she is able to stand with eyes closed. The test should be conducted up to four times for up to a minute. This Sharpened Romberg's test is positive if he/she sways or falls while his/her eyes are closed. This test may not be possible to use on a vessel in motion – it should only be performed on a stable and solid 'platform'.

Part 3 – Section E: **Any Other Relevant Findings not listed Above**

Patient Family name:		**First name:**	
Age:		**Date of birth** (dd/mm/yyyy)**:**	
Country and/or location:			

Time point (please complete date (dd/mm/yyyy) and local time (HH:MM))**:**		
Initial examination:	Date	Time
Pre- or post-therapy:	Pre ☐	Post ☐
This examination:	Date	Time
Therapy number:		
Examination number:		
Name of person examining:		