



EHLTC 2018

ASSOCIAZIONE CARDIOTRAPIANTATI ITALIANI Sezione Friuli Venezia Giulia

Iscritta al n. 743 del Registro Regionale del Volontariato

European Heart and Lung Transplant Championships
11th - 16th June 2018 Lignano Sabbiadoro - Italian Medical Form
(To be filled in only by transplant recipients, please return **before 31st May, 2018**)

Mr – Mrs – Miss (please cross out) - Name: _____ First name: _____
Date of birth ____/____/____ Country _____ Town: _____
Postcode _____ Address: _____
Telephone: _____ Email: _____

Declaration to be signed by the consultant/specialist at the hospital where the patient has his medical follow up

Following a recent check-up and/or effort test, I hereby confirm that the above mentioned patient is fit to take part in sporting activities on the occasion of the 17th European Heart and Lung Transplant Championships to be held from 11th June to 16th June 2018 in Lignano Sabbiadoro - Italy

I **authorize** the patient to take part in the following sports: (please cross out non-authorized sports)

Track and Field: 100m, 400m, 800m (F) or 1500 (M); long-jump, high-jump, ball throw, shot putt; **Cross Country or walk:** 4000m; **Swimming:** 50m, 100m; **Cycling:** 20 km; **Badminton; Tennis; Table tennis; Golf; Volleyball; Petanque; Tambeach.**

Has the transplant recipient suffered from any rejection, major disorders or other complications needing medical/hospital attention during the last 12 months? (please cross out) **YES NO** - If yes, please specify the reason and the current status:

The patient has received: (please cross out the operation that you haven't received) **HT** (Heart) - **LT** (Lung) – **HLT** (Heart and Lung)

Transplantation hospital: _____ Telephone of hospital following patient: _____

Name and phone number of local GP/doctor: _____

Date of transplant ____/____/____ Patient's serum creatinine: _____ µmol/l Sample date: ____/____/____

Ongoing Medication

Ciclosporine: _____ mg/day	Mycophenolate (-mofetil): _____ mg/day
Azathioprine: _____ mg/day	Corticoids: _____ mg/day
Tacrolimus: _____ mg/day	Everolimus: _____ mg/day
Rapamycin: _____ mg/day	other medication: _____
other medication: _____	other medication: _____
other medication: _____	other medication: _____

I confirm that information provided is correct.

Date ____/____/____ **Stamp and Signature of consultant/specialist:** _____

Signature of the Athlete

- I hereby state that all the information I have given to the Lignano 2018 LOC about my health and medical details are correct and up to date.

- I undertake to notify the LOC of any recent health problem.

Date ____/____/____ Signature _____

