



**6th European Transplant and Dialysis Games Dublin 2010  
Medical Certificate Form (Transplant & Peritoneal Dialysis)**

Please return **completed** forms to your Team Managers by June 30<sup>th</sup>  
Incomplete forms will be returned.

<b>Name:</b>		<b>Tel. No.:</b>
<b>Address:</b>		<b>Name and contact number of Next of Kin:</b>
		<b>Team Manager /Country:</b>
<b>Date of Birth:</b>		

<b>Hospital Name:</b>	
<b>Phone Number:</b>	
<b>Consultant / Physician Name:</b>	

**ALL PARTICIPANTS:**

<b>Date of Results:</b>		
<b>Creatinine:</b>	<b>Hb:</b>	<b>BP:</b>
<b>Virology (HIV, Hep B, Hep C): Positive / Negative</b>	<b>Details of virology:</b>	
<b>Musculo skeletal disorder: Yes / No</b>	<b>Diabetes: Yes / No Insulin dependent: Yes/ No</b>	
<b>Vision: Normal / Impaired / Blind</b>		
<b>Warfarin: Yes / No</b>		
<b>Last INR:</b>	<b>Date of INR:</b>	

<b>ALLERGIES:</b>
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<b>MEDICATION:</b>
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