

**INCLUSIVE SKATING**  
**CLASSIFICATION HANDBOOK**

**3rd EDITION**  
**Revised February 2014**



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# 1. INTRODUCTION

## 1.1 BACKGROUND

Ice Skating was not represented in Paralympic Competition in 2010 because there was no classification system and structure to enable competition. Impaired Skating was set up to provide a structure and system for competition for skaters with all forms of permanent impairment including: visual, hearing, biomechanical and intellectual that functionally impact ice-skating (figure skating and speed skating).

Now that the system has been created and implemented and skating events for skaters with a disability have become part of the established event structure impaired Skating has changed its name to Inclusive Skating.

**Skaters wishing to take part in Inclusive Skating Events must be classified and must provide evidence of an impairment that functionally impacts ice-skating. Skaters should use the forms available from page 39 of this Handbook to provide the necessary supporting evidence.**

Inclusive Skating has used the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition (Robert D. Rondinelli, editor) (“Rondinelli Guide or Guide”) as the basis for determining functional impairment. The Rondinelli Guide is a well recognized, widely utilized and validated measure to determine functional impairment. The Guide reflects experience with impairment ratings over the centuries and started in 1958 with publication by the American Medical Association (AMA) article *A Guide to the Evaluation of Permanent Impairment of the Extremities and Back*. Over the next 12 years, 12 additional guides appeared and in 1971 a compendium of these 13 Guides became the first edition of the Guides. The 6th edition of the Guide adopts a contemporary model of disablement that is functionally based and internally consistent. It utilizes the World Health Organization (WHO) and International Classification of Functioning, Disability and Health (ICF) framework for describing and measuring health and disability at the individual and population level with consideration to body function and structure, activity and participation in life situations. This functional approach to classification has also been adopted and encouraged by the International Paralympic Committee (IPC).

The application of the Guides to sport classification is a novel use of the Guide but it is currently the most validated method of measurement of disability, health and functioning. The IPC stresses the importance of a sport specific functional assessment that is relevant to sport performance and the Guide is functionally based to the fullest extent practicable. Moreover, extensive work has been undertaken by medical and skating experts to identify those functional impairments that are relevant to skating performance. Thus the Inclusive Skating classification system is based on the extent of the activity limitations for ice skating. The system allows differences in functional impairments to be measured and athletes with different impairments to equitably compete against each other when performing the same activity.

In considering the functional impact of the impairment on skating account will also be taken of the impact of the impairment on the training process and the ability to acquire the technical skills of ice skating.

There are rateable conditions where the functional impact of the impairment on skating is uncertain; in these circumstances Inclusive Skating classification will default to the Rondinelli Guides.

For the purposes of this classification system the following terms are used:

1. Impairment: a significant deviation, loss, or loss of any body structure or body function in an individual with a health condition, disorder, or disease
2. Disability: activity limitations and / or participation restrictions in an individual with a health condition, disorder, or disease.”

These definitions are taken from the Guides to the Evaluation of Permanent Impairment, 6<sup>th</sup> Edition, p.5, using the International Classification of Functioning, Disability and Health, WHO ICIDH -2.

## **1.2 System Test**

The structure and system of competition for skaters with impairment was tested for the first time at the International Club Competition under ISU Rule 102.17 held at Dumfries Ice Bowl, Scotland on May 12<sup>th</sup> and 13<sup>th</sup> 2012 at a competition held by Impaired Skating with the support of Sk8 Scotland under a permit from the National Ice Skating Association of the UK. The ISU has been kept apprised in writing of all developments of the Inclusive Skating project and has acknowledged in writing its progress. A Report on the event was sent to the ISU and was brought to the attention of the ISU (International Skating Union) Members at the ISU Congress in Kuala Lumpur in June 2012. The ISU encouraged the continued development of the project through the expansion of the next competition to more ISU members.

## **1.3 Review of Classification Handbook**

As a result of the experience gained from running the Dumfries Event in 2012 the Classification Handbook was reviewed at the first conference for classifiers which took place in Glasgow, Scotland in July 2012 and subsequently the second edition of the Classification Handbook was published and was used at the second Inclusive Skating competition held in Dumfries, Scotland on May 11<sup>th</sup> and 12<sup>th</sup> 2013.

As a result of further review and experience gained at the second competition the third Edition of the Classification Handbook has now been published and will be used in all future events.

The Handbook will be reviewed to take account of further experience of application and will in future include case studies and guidance on application.

## 1.4 Role of Classification

The role of classification in inclusive skating is to determine:

- what impairment compensation the skater is awarded
- which classes the skater is eligible to compete in, where appropriate, and
- what additional support should be made available to the skater through the facilitator and/ or modification to the music or starting procedures etc.

**International classification is undertaken before a skater takes part in Inclusive skating competitions and is the responsibility of Classifiers appointed by Inclusive Skating. Skaters wishing to take part in Inclusive Skating Events must provide evidence of an impairment that functionally impacts ice-skating. Skaters should use the forms available from page 39 of this Handbook to provide the necessary supporting evidence**

The handbook also provides information that is needed to understand the application of the Rondinelli Guides to skaters and the various disciplines of ice skating and in particular to provide guidance on the appropriate calculation of the impairment compensation for various impairments.

In time case studies will be added in the medical and classification case review section to increase this understanding and to provide general guidance on the functional application of classification to ice skating.

## 1.5 The Code of Classification

This handbook must be read in conjunction with the Code of Classification for Inclusive Skaters. It is intended that the Classification Rules for Inclusive skating will be in compliance with the IPC Classification Code and any Classification Code to which Inclusive Skating or the ISU (International Skating Union) as the governing body is a signatory.

Although this handbook and the Code may be amended from time to time to ensure that they remain in full compliance with the IPC Classification Code it is intended that the Handbook will contain the day to day practical application of classification guidelines.

Inclusive Skating will maintain a Classification Master List of Skaters including the skater's name, date of birth, country, sport class and sport class status and impairment compensation. The Classification Master List is used to identify Skaters that enter international competitions. Inclusive Skating will make the Classification Master List available to the ISU, the IPC, National Federations and relevant NPCs (National Paralympic Committees).

## 1.6 Applications

Classification should provide skaters with a functional impairment a method to compete equitably in competition and events. When combined with the Rules of Competition and the Announcement of the Event competitions that can occur include:

- Competitions solely for skaters with impairment that include individuals with differing types of impairments.
- Competitions for skaters with similar impairments. This would allow skaters to take part in existing specific disability sport events such as World Winter Games for Special Olympic athletes and Blind Sport Events etc.
- Competition within current skating events where skaters with an impairment compete against non-impaired skaters, with adjustment by the impairment compensation to reflect the degree of functional impairment.

### **1.7 Calculation of Result**

The classification process will determine the degree of impairment relative to a whole person impairment. The whole person impairment is then related to a known constant of a skating score or time that is the average hypothetical score or time of an able bodied skater performing that activity. This will be known as the 'impairment compensation'. The competition score will be a measure of the evaluated performance or time and the impairment compensation.

## **2. THE CLASSIFICATION SYSTEM**

### **2.1 INTRODUCTION**

The Inclusive Skating Classification System offers figure, speed and solo dance events for skaters (with or without a facilitator) with any impairment that functionally limits ice skating.

Where the impairment results in the skater being non-ambulant or limited to short distances indoors then additional equipment for support or mobility may be used.

Equipment to aid participation in any way may be allowed but should be considered during the classification process.

### **2.2 CLASSIFICATION OF SKATERS**

Skaters may be classified for Inclusive Skating events if they have and meet all of the following criteria:

- Impairment capable of evaluation under the Guides to the Evaluation of Permanent Impairment, 6<sup>th</sup> Edition, (Rondinelli guides)
- The impairment meets the sport specific minimum impairment criterion.

Classification includes ALL the impairments that the skater has and the impairment compensation will be combined following the Rondinelli Guides to reflect the skater's full impairment.

A skater who does not meet the conditions for minimal impairment, is not eligible to obtain impairment compensation and will not be classified.

For the purposes of Inclusive Skating events the classification provided by disability specific sports shall not be considered. Disability Specific classification systems will however apply to Disability Specific Competitions that take place during Events run by Inclusive Skating.

### **2.3 THE CLASSIFICATION PATHWAY**

This classification pathway must be read in conjunction with the more detailed provisions of the Inclusive Skating Code of Classification.

### **2.4 SUPPORTING DOCUMENTATION**

When attending for classification the skater is required to produce:

- Evidence of identity
- Passport sized photograph
- Copies of Medical documentation that supports/ describes the impairment (in English language).

For guidance on what information should be provided skaters should use the Physician Reporting forms at the end of this Handbook. Forms are provided for all impairments that functionally limit ice skating. Skaters should provide information on ALL impairments that are to be included in their classification.

Impaired Skating may require a skater to provide further detailed specialist medical documentation and the Chief Classifier has the discretion not to determine eligibility without this documentation. It is the responsibility of the Skater and the National Federation of the Skater to ensure that any skater whose impairment is the result of a rare or uncommon condition provides supporting specialist documentation in English when presenting the skater for evaluation.

Skaters should wherever possible provide evidence of their medical condition that meets the standards provided for in the Rondinelli Guides.

## **2.5 CLASSIFICATION CONSENT FORM**

The skater must consent to evaluation by signing a CLASSIFICATION CONSENT FORM and/or completing the Competition Entry form to indicate their agreement to be classified and confirm their agreement to provide full effort and co operation during the classification process.

## **2.6 PRESENTATION FOR EVALUATION**

The skater must dress appropriately and must bring all equipment including competition or daily use prosthesis or othoses and any hearing or visual aids.

If a skater wishes to use any assistive device or aid during competition then they must be classified with that device and obtain an impairment compensation on that basis.

The skater may be accompanied by an interpreter and not more than one representative of the Skater's NPC or National Federation.

Where possible the skater's facilitator should be available to attend the evaluation or for consultation about the skater's needs during competition.

If the Skater has a health condition that produces pain, which limits or prohibits full effort during evaluation, it may not be appropriate for evaluation for classification to take place at that time. It may be possible to reschedule the classification but ultimately the Skater will not be eligible to compete at international level and obtain impairment compensation until such an evaluation and classification is satisfactorily completed.

## **2.7 ASSESSMENT**

The classification panel will conduct a physical assessment of the skater when indicated. This will include but is not limited to the examination of motor



power, muscle tone, co ordination, range of movement and observation of any residual ability to ambulate.

Video footage and/or photography may be utilized by the classification panel for all purposes connected to the competition and the evaluation.

The classification panel will review all medical evidence and records.

The skater may be required to undertake further tests and will be observed during practice and competition to ensure an enduring level of ability demonstrated on clinical exam for a period of time. This time will initially be set for 2 years.

## **2.8 OUTCOME – SPORT CLASS ALLOCATION**

A member of the Classification Panel will inform the skater of the panel's decision. It is expected that this will occur as soon as possible after the decision has been taken.

### **Sport Class Status New (N)**

When skaters have not previously been classified by an international Classification Panel then they will be assigned Sport Class New (N).

Sport Class Status N skaters include those who have been allocated a sport class by their National Federation for entry purposes.

Sport Class N skaters must complete classification prior to competing at Paralympic Winter Games, Inclusive Skating World Championship or Qualifying events and any International and /or National events where the skater wishes to obtain impairment compensation.

### **Sport Class Review (R)**

Sport Class Review (R) status may be assigned to skaters, following classification by an Inclusive Skating Classification Panel, for a period of time.

All skaters should expect to be assigned Sport Status R for a minimum period of time of 1 year of competitive skating.

During the development phase of Inclusive Skating it is intended that all skaters will have Sport Class Status R.

Sport Class Review Status (R) is assigned to a skater who has been previously classified by an Inclusive Skating Classification Panel but for reasons determined by the Inclusive Skating Head Classifier requires a review of their sport class for example because their condition appears to have changed.

Sport Class Status R Skaters must complete classification prior to competing at Paralympic Winter Games, Inclusive Skating World Championship or Qualifying events and any International and/ or national events where the skater wishes to obtain impairment compensation.

### **Sport Class Confirmed (C)**

Sport Class status of confirmed (C) may only be allocated following classification by certified Inclusive Skating classification panel/ classifiers.

When a skater has confirmed status further classification is not required.

The status of a Skater whose classification is confirmed cannot be protested by another NPC or NF after it comes into effect. Confirmed status is deemed to come into effect 24 hours after first appearance of the skater at the first international competition following the process of evaluation.

## **2.9 INELIGIBILITY**

In Inclusive Skating the allocation of sport class is either:

- Eligible (ISE), or
- Non Eligible (ISNE)

In circumstances where a Sport Class of ineligible to compete is allocated by a classification panel then the skater has a right to be examined again by a second classification panel at a later date. The second classification panel should contain new members who did not take part in the first classification. If the second classification panel confirms the ineligibility the skater will not be permitted to compete and will have no further protest options.

## **2.10 CLASSIFICATION PROTEST**

A classification protest is the procedure whereby a formal objection to a skater's sport class is made and subsequently resolved.

A skater's sports class should generally only be protested once with the exception of protests in exceptional circumstances.

A classification protest shall be resolved by a new classification panel that was not involved in the allocation of the sports class that is being protested.

Classification protests will generally be submitted during competition and can be submitted by a designated representative of an NPC or NF, the Chief Classifier or by the Inclusive Skating Head of Classification.

Skaters who have undergone classification of eligibility either as new (N) or Review (R) designations can only be the subject of classification protest within a period of 24 hours following first appearance at the first international

Competition following evaluation. Protests must be submitted to the Chief Classifier within that period otherwise the protest will be void.

Skaters with a confirmed status cannot be the subject of a protest from an NPC/NF but can be the subject of a protest by the Chief Classifier.

## **2.11 POST-EVALUTION TASKS**

Written notification of the Classification must be provided to the Skater. An Inclusive Skating Passport is completed identifying the Impairment Compensation, the class of the skater (where appropriate) and any specific impairment classes.

## **2.12 APPEAL**

An appeal is the procedure by which a formal object to the manner in which classification procedures have been conducted is submitted and subsequently resolved.

The Appeal body shall have jurisdiction to review classification decisions in order to

- Ensure all appropriate sports class classification procedures have been followed
- Ensure all appropriate protest procedures have been followed.

But no Appeal body shall have jurisdiction to review the merits of an allocation of Sports Class or Sports Class Status and under no circumstance shall the appeal body modify a classification decision by allocating a new Sports Class or Sports Class Status.

## **2.13 POST-COMPETITION TASKS**

The Chief Classifier must complete a post competition report, which is then forwarded to the Head of Classification. The Head of Classification has the responsibility of updating the Classification Master List after each competition at which classification has taken place.

### 3. COMPETITION LEVELS

The Inclusive Skating Classification and Competition System offers figure, speed and solo dance events for skaters (with or without a facilitator) with any impairment that functionally limits ice skating.

#### 3.1 – SPEED LEVELS/ CLASSES

The rules of competition follow the ISU Rules for long track but use a time trial format.

Where appropriate the ISU short track and Special Olympic rules may apply to Disability specific events held as part of an Inclusive Skating Event.

Skaters should refer to the more detailed rules in the rules of competition and the Announcement of the Competition.

Race distances may be limited to those with a range of whole person impairment and according to the age and development of the skater.

Events may also be split according to a specific impairment grouping, e.g. intellectual/ non-biomechanical (I), visual (V) , hearing (H), biomechanical (B) etc. As a general rule the following classes will apply.

- **Speed Class 1** – paraplegia with no or some upper abdominal function and no functional sitting balance. Such skaters use an ice sledge. (this compares to sitting skiing classes LW 10)
- **Speed Class 2** – paraplegia with fair functional sitting balance. Such skaters use an ice sledge. (this compares to sitting skiing classes LW 11)
- **Speed Class 3** – for skaters with limited ability to ambulate. Such skaters use an aid to support standing and skating on the ice.
- **Speed Class 4** - Skaters who require a facilitator for guidance in direct contact or in close proximity
- **Speed Class 5** - Skaters who are independently ambulant.

#### 3.2 GENERAL RULES FOR FIGURE and DANCE LEVELS

Ambulant skaters may enter inclusive skating competition at the technical level of skating that the skater, in consultation with their coaches, most closely matches their technical skating ability. There are no test requirements. The skater has a duty to skate at their current level of skating ability given their impairment and skaters must not skate below their ability. The coach has the a duty to ensure that the skater's health, safety and well-being is paramount and that the skater skates at their appropriate skating ability level.

The following provides a general template of the technical expected progression of skating skill at each level to be used during classification in order to assess the expected technical level for participation. Refer to the detailed rules of competition for the full technical requirements at each level.

Levels may also be split according to a specific impairment grouping, e.g. intellectual/ non-biomechanical (I), visual (V), hearing (H), biomechanical (B) etc. and according to the age and sex of the skater.

### 3.3 FIGURE LEVELS

- **Figure Level 1**- ability to skate on 2 feet in 1 minute program, Average IJS score of 2.45 with ISU PCS score of 0.25 when 2.5 factor used (0.5 and 0.75 when 1.0 factor used)
- **Figure Level 2**- ability to skate on 1 foot in 1 minute 30 second program, Average IJS score of 4.25 with ISU PCS score of 0.5 when 2.5 factor used (0.75 and 0.75 when 1.5 factor used)
- **Figure Level 3** – ability to skate on forward 1 foot edges and simple  $\frac{1}{2}$  rotation jumps in 2 minute program, Average IJS score of 6.2 with ISU PCS score of 0.75 when 2.5 factor used (1.00 and 0.75 when 2.0 factor used)
- **Figure Level 4** – ability to do  $\frac{1}{2}$  revolution jumps in combination and loop jump in 2 minute program. Skater should be able to skate backwards on 1 foot edges. Average IJS score of 9.6 with ISU PCS score of 1.0 when 2.5 factor used
- **Figure Level 5** – ability to do all single rotation jumps (but not axel or double jumps) in 2 minute 30 second program, Average IJS score of 12.3 with ISU PCS score of 1.25 when 2.5 factor used.
- **Figure Level 6** – ability to do Axel and double jumps (but not required to comply with technical requirements of ISU Novice Basic A or B requirements) in 3 minute program, Average IJS score of 15.2 with ISU PCS score of 1.5 when 2.5 factor used
- **Figure Level 7** – ability to do all double jumps and comply broadly with ISU Junior requirements in a 3 minute 30 second program for girls and ladies and a 4 minute program for boys and men. Average IJS score of 48.0 for Lady and 58.0 for Men. Average performance component score of 3.0
- **Figure Level 8** – ability to do triple jumps and comply broadly with ISU Senior requirements in a 4 minute program for ladies and 4 minute 30 second program for boys and men. Average IJS score of 55.0 for Lady and 68.0 for Men. Average performance component score of 3.5

### 3.4 SOLO DANCE LEVELS

The following provides a general template of the technical expected progression of skating skill at each level.

Skaters may skate with a facilitator/ partner in the same way that a skater takes a test.

- **Solo Dance Level 1** - Dutch Waltz, Canasta Tango, Rhythm Blues  
Ability to skate on 1 foot and cover centre of the full rink with assistance. Average IJS performance component skating skill score of below 0.50.
- **Solo Dance Level 2** - Cha-Cha, Fiesta Tango, Swing  
Ability to skate on 1 foot forward edges and cover full rink when assisted. Average IJS performance component skating skill score of 0.50
- **Solo Dance Level 3** - Ten Fox, Willow Waltz, Hickory Hoe Down  
Ability to skate on 1 foot back edges and independently cover full rink with power. Average IJS performance component skating skill score of 1.00
- **Solo Dance Level 4** - Fourteen Step, European Waltz, Foxtrot  
Ability to skate some basic turns independently and with power. Average IJS performance component score skating skill of 1.50
- **Solo Dance Level 5** - American Waltz, Tango, Rocker Foxtrot  
Ability to perform some complicated turns and skate most basic turns independently and with power. Average IJS performance component skating skill score of 2.00.
- **Solo Dance Level 6** – Killian, Paso Doble, Blues  
Ability to perform most complicated turns without assistance and with power. Average IJS performance component skating skill score of 2.50.
- **Solo Dance Level 7** - Westminster Waltz, Quickstep, Argentine Tango  
Ability to perform full range of skating movements. Average IJS performance component skating skill score in excess of 3.00

### 3.5 LEVELS AND CLASSES

The level and class of the skater may be different. The level of the skater reflects the technical skating of the skater. The class of the skater will determine the impairment compensation and the functional performance class for the skater where appropriate.

## **4 GENERAL GUIDELINES FOR CLASSIFIERS**

### **4.1 CLASSIFIERS**

Classifiers are either medically qualified as registered medical practitioners or registered physiotherapists or are technically qualified as skaters or coaches.

Inclusive Skating requires documentation confirming the professional qualifications of potential classifiers prior to appointment.

Classifiers will be certified after undergoing training which includes both theoretical and practical aspects and an assessment of required competencies in carrying out classifications and applying the classification rules of inclusive skating.

Any certified classifier who has not performed any classifications or performed classification duties at international level for 2 years will be required to undergo retraining.

### **4.2 CLASSIFICATION PANEL**

Classifiers will work as members of a classification panel, which has at least 2 members. At least one member should be medically qualified and one member should be technically qualified.

There may be an interim requirement for classifiers to work alone at times until the appropriate expansion of classifiers occurs.

### **4.3 CLASSIFICATION DUTIES DURING COMPETITION**

During a competition members of a Classification Panel should not have any responsibilities towards or attachment to a National Team/ Squad or expectations for medical event coverage.

### **4.4 CHIEF CLASSIFIER**

A Chief Classifier is appointed for a specific competition. The Chief Classifier may be the Head of Classification or it may be another fully certified international classifier.

The Chief Classifier will ensure that the classification rules are applied appropriately during the specific competition and that classification facilities are provided at and during the competition, which allow high professional standards to be maintained.

The Chief Classifier shall maintain a record of the certified classifiers at the competition and shall send this information to the Head of Classification.



#### **4.5 HEAD OF CLASSIFICATION**

A Head of Classification, appointed by Inclusive Skating (or the ISU and/or the IPC where appropriate), will have over all responsibility for international classification, classifier training and supervision, maintaining secure classification data and regularly updating it and ensuring such records are accurate, as well as liaising with all relevant external parties such as the International Paralympic Committee (IPC) Classification committee, IPC Medical and Scientific Department and Organising Committees.

The Head of Classification shall maintain a list of certified classifiers and the events at which each has undertaken classification duties.

#### **4.6 CONDUCT OF CLASSIFIERS**

The role of the classifier is to act as an impartial evaluator in determining a skater's eligibility and Sport Class status. The integrity of Classification in the Paralympic movement and Inclusive Skating rests on the professional conduct and behaviour of each individual classifier. It is important that confidence in the Classification Rules and the Classification Personnel is preserved and developed and that it is based on transparent and agreed standards of practice which define a meaningful set of guidelines for the professional conduct of classification personnel.

All classifiers must abide by the Inclusive Skating Officials Policy Manual and in particular the Code of Conduct for Officials and should at all times respect the Classification rules.

Classifiers should value and respect the Skaters and Skaters Support Personnel and treat them with understanding patience and dignity while being courteous, objective, honest and impartial in performing their classification duties.

Classifiers should accept responsibility for all actions and decisions taken and be open to discussion and interaction with Skaters and Skaters support personnel in accordance with the International Standards for Skater Evaluation and International Standard for Protest and Appeals.

Confidentiality of Skater information must be maintained and whenever possible according to the International Standards for Skater Evaluation and Protests and Appeals.

Simple medical tools comprising a stethoscope, reflex hammer, goniometer, tape measure, otoscope, ophthalmoscope and Snellen chart should be available and large tables used to enable simple clinical assessment with skaters sitting on the tables for lower limb examinations. The WHO standards or current UK height to weight charts for children are both suitable and may be used for classification.

#### **4.7 THE BASIS OF CLASSIFICATION**

Inclusive Skating and the classifier body will promote and stimulate studies which endeavour to provide a scientific basis to underpin the scheme of classification and the development of technology that will facilitate the development of inclusive skating and participation by ice skaters with an impairment.

Such research would be expected to enhance confidence in the classification system and encourage its future development.

## **5 CODES OF CONDUCT**

Inclusive skating Rules set out a consistent policy, which seeks to put the skater first and ensures fair play and contains mechanisms, which protect the rights of all skaters and of classifiers in the classification of skaters and a thorough system of Protests and Appeals, should there be any individual breakdown in the process of classification.

The classification rules are included in the Inclusive Skating Rules, Official Policy Manual for Inclusive Skating, and follow the ISU Rules and the rules of any relevant national governing body for ice-skating and sport. All participants in the sport of inclusive Skating accept these rules as a condition of participation in inclusive skating events.

## 6. MINIMAL IMPAIRMENT CRITERIA

Skaters who do not meet the conditions for minimal impairment, are not eligible to obtain impairment compensation and be classified. They are eligible to compete in the skating result where a unified event between able bodied skaters and skaters with an impairment is taking place.

The minimum impairment under the Rondinelli Guides to apply to ice skating is generally set at 5% or less whole person impairment (WPI). This figure may however be adjusted depending on the impairment.

If in the view of the Classification Panel or the Head of Classification a skater meets the minimal impairment criteria and has not provided sufficient evidence to establish the precise impairment compensation to be added to their skating score then the skater should be deemed to be 5% whole person impaired and the relevant impairment compensation should be added to their skating score and an impaired compensation skating score should be awarded to the skater.

An athlete, who has two or more impairments, none of which meet the minimum level, may be eligible to compete providing they meet the minimum combined percentage assessed under the Rondinelli Guides.

The impairment must impact on the skater's ability to compete equitably in able-bodied competition.

Impairments that do not functionally impact or impact only temporarily on the ability to skate are excluded from classification.

The decision of the classifiers on the impairments that do not meet the minimal impairment criteria and do not functionally limit ice skating is final and is not subject to protest or appeal.

Impairments that are excluded include the following:

- Adjustments for Pain
- Burden of Treatment Compliance
- In solo figure or speed skating, impairments distal to wrist
- Psychiatric disorders are not included as they have an unquantifiable effect and have a variable impact upon skating performance.
- Somatic syndromes (such as ME, Chronic Fatigue Syndrome, fibromyalgia) where the primary problem is lack of energy, lack of motivation or pain in the absence of a substantial underlying pathological process. These are not suitable for classification due to a lack of objective medical criteria.

## 7. DISABILITY SPECIFIC COMPETITION CLASSES

### 7.1 PARALYMPIC

With training a skater may achieve a paralympic class. The skater's paralympic competition class is the average level of attainment of a skater with that particular functional impairment. The level for paralympic participation will be determined during the classification process and the class will be determined and adjusted over time as data on the average level of attainment for each impairment type becomes available. This workstream is still on-going and will be published when there is sufficient data.

The skater's impairment compensation will apply to the calculation of the result within the competition class.

The classification process will determine the degree of impairment relative to a whole person impairment. The whole person impairment is then related to a known constant of a skating score or time that is the average hypothetical score or time of an able bodied skater performing that activity. This will be known as the 'impairment compensation'. The competition score will be a measure of the evaluated performance or time and the impairment compensation.

Paralympic Classes will include the following sub-groups of impairment following the rules of the IPC on impairments that are included in paralympic events.

General sub-groups are as follows:

Loss of Power, for example

- Spinal cord injuries or spinal cord conditions
- Poliomyelitis
- Transverse myelitis
- Spina Bifida
- Polyneuropathy

Lower Limb Deficiency, for example

- Amputations
- Unilateral hip disarticulation

Hypertonia, for example

- Cerebral palsy
- Other forms of hypotonia

Inco-ordination, for example

- Multiple Sclerosis

- Other forms of inco-ordination in the lower limbs, possibly in conjunction with loss of strength and hypotonia with the objective signs of ataxia.

Restriction of Movement, for example

- Arthrogyposis
- Other forms of loss of joint range in combination with loss of strength

Musculoskeletal impairments, congenital anomalies, nerve lesions and other impairments that meet the sport specific minimum impairment levels. For example,

- Traumatic brain injury
- Stroke

Skaters who are visually impaired

Skaters who are intellectually impaired

## **7.2 SPECIAL OLYMPICS**

Inclusive Skating events may include Special Olympic events.

Skaters who are intellectually impaired and meet the Special Olympics Classification guidelines will skate in the following Levels in accordance with Special Olympic Rules and must complete both the Figure Level program and the compulsory elements group for the same level. Broadly, Special Olympics classification includes those who have an intellectual impairment that has manifested itself before 21 and have an IQ of less than 75 and will be determined by Special Olympics Classification processes.

No impairment compensation is awarded in the calculation of Special Olympic Results at present.

See the Rules of competition for full details of the technical requirements.

## **7.3 BLIND SPORT**

Inclusive Skating events may include Blind Sports Events.

Blind Sports events will include Skaters who are visually impaired and meet the definition of the relevant blind sports associations, for example B1, B2, B3, B4 and B4+ from the British Blind Sports Association and the International Blind Sports Association. This classification will be determined and administered by Blind Sports Classification processes.

Skaters are only required to skate the free skating program in the Figure event and are not required to perform the compulsory elements group.

#### **7.4 DEAF SPORT AND DEAFLYMPICS**

Inclusive Skating events may include Deaf Sport and Deaflympics Events

Deaf Sport and Deaflympic events will include Skaters who are hearing impaired and meet the definition of the Deaflympics and/or other relevant hearing impaired associations. For the purposes of the Deaflympics deafness is defined as hearing loss of at least 55db in the better ear (3-tone frequency average at 500, 1000 and 2000 Hertz, ISO 1964 Standard and any further amendments or modifications to this definition by the ICSD and Deaflympics shall be deemed to be automatically incorporated.

#### **7.5 OTHER SPECIFIC DISABILITY EVENTS**

Inclusive Skating Events may include any Disability Specific Events. If skaters meet the specific disability criteria for a specific disability organization then the general Inclusive Skating Levels 1 to 8 should as a general rule apply to define the skating levels for competition and the classification criteria of the specific disability organization should be applied to determine who is eligible to compete in the event.

## 8. APPLICATION OF RONDINELLI GUIDES TO SKATING DISCIPLINES

This section summarises how the American Medical Association Guides to the Evaluation of Permanent Impairment (Sixth Edition) should be adjusted for application to solo figure, solo dance and speed skating disciplines. The Rondinelli Guides provide an established methodology for quantifying the degree of impairment, based upon the underlying medical diagnosis and its functional effects.

### 8.1 How the guides work

Impairments are considered by disease type and are given up to four separate classes for the magnitude of the effect. Objective medical criteria are utilised in addition to symptom descriptors to minimise inter-rater variability. The different classes have a range of impairment for the system affected and for the whole person. Classes are given a range of values for impairment with the mid point being the default value. Greater precision can be achieved by the use of sub-scales. Whole person impairments of different types can be added together for individuals with multiple disabilities.

### 8.2 Specific Chapter adjustments

#### Chapter 3 - Pain

There is no additional adjustment for pain-related impairment as it cannot be objectively quantified and the effect of pain on function is already reflected in the overall assessment of the disability.

#### Chapter 4- Cardiovascular

Cardiovascular performance is directly relevant to performance in all ice skating disciplines. The Rondinelli guides utilise the New York Heart Association classes (page 48).

Class I indicates that no impairment of ordinary activity and should be classified at 6% for ice skating.

At Class II classify at the midpoint.

Class III and Class IV are particularly relevant to skating and the upper limit of the class range should be used. (Class III 40% WPI and Class IV 65% impairment)

Sub-type	Page	Table	Comments
Valvular	53	4-5	Class 1 classify at 6%, Class 2 classify at 17%, Class3 40%, Class 4 65%.
Coronary artery disease	55	4-6	Class 1 classify at 6%, Class 2 classify at 17%, Class3 40%, Class 4 65%.
Cardiomyopathies	59	4-7	Class 1 classify at 6%, Class 2 classify at 17%, Class3 40%, Class 4 65%.



Pericardial heart disease	61	4-8	Class 1 classify at 6%, Class 2 classify at 17%, Class 3 40%, Class 4 65%.
Dysrhythmias	64	4-9	Class 1 classify at 6%, Class 2 classify at 17%, Class 3 40%, Class 4 65%.
Hypertensive cardiovascular disease	67	4-11	Classify only Class 3 and 4 and classify using NYHA. NYHA Class 2=17%, Class 3=40% Class 4=65%
Upper and lower extremity peripheral vascular disease	69 and 70	4-12 and 4-13	These disorders would be particularly disabling for the skating disciplines and the upper limit of the classification ranges should be used
Pulmonary artery diseases	72	4-13	Class 1 classify at 6%, Class 2 classify at 17%, Class 3 40%, Class 4 65%.

## Chapter 5: The pulmonary system

Pulmonary system performance is directly relevant to performance in all skating disciplines. Assessment of level of dyspnoea is described in table 5-1 page 79 and is utilised in classification for pulmonary dysfunction, excluding asthma.

Pulmonary function test results will be the critical factor in classification and must be provided pre and post bronchodilator.

Spirometry at the rinkside after use of bronchodilator may also be considered.

Sub-type	Page	Table	Comments
Pulmonary dysfunction	88	5-4	Class 1 meets minimum level for classification (6%) and is directly relevant to skating. It should be classified as 6% impairment. Classes 2, 3 and 4 should be classified at the upper end of the WPI scales (23%, 40%, 65%)
Asthma	90	5-5	Class 1 meets minimum level for classification (6%) and is directly relevant to skating. It should be classified as 6% impairment. The clinical parameters however in this section are not helpful as they are descriptors of medication used, not of functional impairment. The maximum post-bronchodilator FEV1 (as % of expected) is critical to accurate evaluation in this category.

## Chapter 6: Digestive system

Digestive disorders are relevant where they are substantial such that they

- interfere with the ability to train consistently
- result in difficulty in maintaining normal nutrition such that they interfere with the performance of a planned programme of specific duration in a timetabled programme of performances.

Refer to desirable weight tables 6-1 and 6-2 for men and women, page 105 or WHO standardized charts. For children – consider use of age-specific charts demonstrating a difference in height to weight of one SD or both height and weight below 25<sup>th</sup>. Percentile.

Obesity is not rateable.

History of symptoms and objective medical evidence of digestive disorder may be critical.

Adjustments to timetabling to enable a competitor to skate first after a warm-up session may reduce the impact of the disability.

Adjustment of the scales is appropriate to reflect the less direct impact upon skating disciplines when compared to other types of disability (such as cardiac or mechanical impairments).

The recommendation is to use the lowest value of the Class scales for most disorders to reflect the relative impact of these disorders on skating disciplines.

Class 1 will therefore be unclassified as the minimum impairment of 5% will not be met.

<b>Sub-type</b>	<b>Page</b>	<b>Table</b>	<b>Comments</b>
Upper digestive tract	107	6-4	Use lowest class value. Class 2 would have a WPI of 12%, Class 3 would be 22%, Class 4 would be 40%
Colonic and rectal disorders	114	6-5	Use lowest class value. Class 2 would have a WPI of 12%, Class 3 would be 22%, Class 4 would be 40%
Anal disease	116	6-6	Use lowest class value. Class 2 would have a WPI of 6%, Class 3 would be 21%, Class 4 would be 22%
Stomas	118	6-7	Use lowest class value. Classify the underlying impairment at lower end of the default range and add 5% stoma to the value using the combined values chart
Liver disease	119	6-8	Use lowest class value. Class 2 would have a WPI of 15%, Class 3 would be 30%, Class 4 would be 45%
Biliary tract disease	120	6-9	Use lowest class value. Class 2 would have a WPI of 11%, Class 3 would be 21%, no class 4.
Herniation	122	6-10	As hernias are directly relevant to skating disciplines, use the normal default values (middle of the range of Class values). Class 1 is below minimum level for classification

## Chapter 7: Urinary and Reproductive

As indicated at page 131, such conditions never present or occasional (present up to 33% of the time) should not be given a rating, unless Activity of Daily Living's (ADL's) are significantly adversely affected. This will exclude most minor intermittent conditions affecting an individual for around one week a month or two days per week.

Urinary disorders are relevant where interfere with the ability to train consistently.

Adjustments to timetabling to enable a competitor to skate first after a warm-up session may reduce the impact of the disability.

Adjustment to the scales is appropriate to reflect the less direct impact upon skating disciplines when compared to other types of disability (such as cardiac or mechanical impairments).

Inclusive Skating uses the lowest value of the Class scales for urinary and reproductive disorders to reflect the relative impact of these disorders on skating disciplines.

Class 1 level of function will therefore be unclassified as the minimum impairment of 5% will not be met.

Sub-type	Page	Table	Comments
Upper urinary Tract	134	7-2	Use lowest class value. Class 2 would have a WPI of 16%, Class 3 would be 36%, Class 4 would be 55%
Stomas	138	7-3	Classify the underlying disability using the lowest value and then add the medial value for the stoma
Bladder disease	139	7-4	Use lowest class value. Class 2 would have a WPI of 11%, Class 3 would be 21%, Class 4 would be 55%
Urethral disease	141	7-5	Use lowest class value. Class 2 would have a WPI of 7%, Class 3 would be 16%, Class 4 would be 24%
Penile, scrotal, testicular, prostatic, vulval, vaginal, cervical, uterine, fallopian or ovarian disease	144-154	7-6 to 7-12	These are not directly relevant to skating so should not be classified.

## Chapter 8: Skin

Skin conditions are relevant to skating where they affect the face, hands or neck, AND cannot be concealed AND affect ADL's to a significant extent.

Refer to table 8-2 on page 166

Use the Class 2 column and the lowest value for Class 2 (11%), the middle value for Class 3 (19%) and the highest value for Class 4 (27%).

## Chapter 9: Blood

Circulation of healthy blood is a key factor in exercise.

Table 9-2 Eastern Co-operative Oncology Group Performance Status Scale (ECOG-PSS) on page 185 is indicative of the functional effects of some of these conditions.

Sub-type	Page	Table	Comments
Anaemia	189	9-5	Directly relevant to skating: use unadjusted mid point of scales with Hb concentration and transfusion requirements informing the classification
Neutropenia	194	9-6	Does not directly affect exercise capacity but affects training and competition: Exclude Class 1 and 2 and use lowest class values (Class 3 25%, Class 4 40%). Unlikely to compete if severe.
Leukaemia	196	9-7	Use ECOG-PSS and mid-point of scale.
HIV	199	9-8	Use ECOG-PSS and mid-point of scale.
Platelet disorders	202	9-9	Mid-point of scales
Haemophilias and bleeding disorders	204 and 205	9-10 and 9-11	Mid-point of scales Does not directly affect exercise capacity but affects training and competition: Exclude Class 1 and 2 and use lowest class values (Class 3 25%, Class 4 40%). Unlikely to compete if severe.
Thrombotic disorders	208	9-12	Not directly relevant to skating: classify if are significant restrictions of ADLs due to the effects of thrombus or its treatment. Classify if post-thrombotic syndrome is present (using lower limb classification) or classify for dyspnoea following PE (using pulmonary scale). Give 5% (as per page 207) for long-term warfarin or other medications known to have a potential for excessive bleeding and require laboratory monitoring.
Lymphoma and metastatic disease	209	9-13	Use ECOG-PSS and mid-point of scale.

## Chapter 10: Endocrine

Many of these disorders will not be classified if effects (after maximum medical improvement) are minor and rarely present. Most disorders are unlikely to leave significant residual symptoms with effective treatment and the impairment scales are heavily influenced by burden of treatment compliance.

For this reason, the lowest value in the scale is used. Consider whether skating first after the warm-up would minimise the effect of the disability.

Sub-type	Page	Table	Comments
Hypothalamic-Pituitary axis	220	10-5	Use lowest class value. Class 3 (WPI 7%) and Class 4 (WPI 10%) if residual effects are present when skating.
Thyroid	223	10-6	Cosmetic effects: no effect on skating function when treated so do not classify
Parathyroid disorders	224	10-7	Use lowest class value: none would qualify. Classify any metabolic bone disease (osteodystrophy) separately – as per 10-14
Adrenal cortex disorders	227	10-8	Use lowest class value Class 3 (WPI 5%) and Class 4 (WPI 10%) if residual effects are present when skating
Adrenal medulla disorders	231	10-9	Class 2 (WPI 6%), Class 3 (WPI 20%) and Class 4 (WPI 40%) if residual effects are present when skating.
Diabetes Mellitus	234	10-10	Only Class 4 (16-28%) would be relevant to skating (poor control despite maximum therapy). Default value for this class should be 16%. Skate first after warm up.
Hypoglycaemia	237	10-11	Use lowest class value so would not be classified. Skate first after warm-up.
Gonadal disorders	239	10-12	Not relevant to skating
Mammary disorders	240	10-13	Classify under musculo-skeletal chapters if there is a post surgical impairment of movement
Metabolic Bone disease	242	10-14	Classify under musculo-skeletal chapters if there is an impairment of movement.

## Chapter 11 – Ear, nose, throat and related structures

Hearing loss is relevant to all skating disciplines. In speed skating hearing is used for orientation when competing against another in the track.

The Inclusive Skating classification formula for calculation of hearing loss is consistent with other international systems for measuring hearing impairment for disability purposes.

Binaural loss= (5x %better ear plus 1x% worse ear) all divided by 6.

Sub-type	Page	Table	Comments
Hearing impairment	250 252 254	11-1 11-2 11-3	calculate binaural hearing impairment and table 11-3 (page 254) to convert this to WPI.
Tinnitus	249	none	Unlikely to interfere with skating: do not classify
Vestibular disorders	258	11-4	By definition, only class 1 are likely to skate: Classify at mid point of class value (WPI 5%).
Facial disorder/disfigurement	262	11-5	Classify if air passage deficit is present
Air passage deficits	267	11-6	Classify at mid point of class value. In exceptional cases only will Class 2 or higher apply in skating – evidence for significant persistent physical abnormality would be needed.
Mastication	269	11-7	Do not classify
Voice and speech	274	11-8	Do not classify

### Hearing

Utilise table 11-1 (Page 250) and 11-2 (page 252) to calculate binaural hearing impairment and table 11-3 (page 254) to convert this to WPI. The better ear is weighted as contributing 5/6<sup>th</sup> of the binaural ability and the poorer ear as 1/6<sup>th</sup>, averaged over the 0.5, 1. 2 and 3KHz range.

### Chapter 12 – Visual System

Sight disorders are particularly relevant to skating disciplines.

The assessment requires three separate steps: assessment of acuity, assessment of fields and combination to give assessment of the visual system as a whole.

Skaters must provide evidence of the corrected visual acuity and visual field. In practice, the descriptors used appear to be a good estimate of the binocular visual acuity.

**Visual Acuity – table 12-2 page 288.**

Assess in each eye separately then binocularly and combine using the formula at table 12-3 page 289 [ (right x1) plus (left x1) plus (binocular x3) ] divided by 5 to determine the functional acuity score.

Subtract from 100 to determine the acuity-related impairment.

**ready reckoner (from table 12-2 page 288)**

6 m	1 m	20 feet	decimal	VAS (ability)	Impairment (loss)
6/6	1/1	20/20	1.0	100	0
6/12	1/2	20/40	0.5	85	15
6/24	1/4	20/80	0.25	70	30
6/60	1/10	20/200	0.1	50	50
6/120	1/20	20/400	0.05	35	65
6/240	1/40	20/800	0.025	20	80
6/480	1/80	20/1600	0.0125	5	95
6/600	1/100	20/2000	0.01	0	100 (Blind)

**Hand and counting fingers ready reckoner**

Counting	Distance	6m notation	20 feet	decimal
Fingers	3 m or 10 feet	3/60=6/120	10/200=20/400	0.05
	2 m or 6 feet	2/60=6/180	6/200=20/660	0.03
	1 m or 3 feet	1/60=6/360	3/200=20/1100	0.017
Hands	2 m or 6 feet	2/300=6/900	6/1000=20/3300	0.0067 (Blind)

**Visual Fields – Table 12-5 page 296**

Assess for each eye separately then assess for binocular vision. Combine with the formula on page 297 [ (right x1) plus (left x1) plus (binocular x3) ] divided by 5 to determine a functional field score.

Subtract from 100 to determine the field- based impairment rating.

Concentric loss (tunnel vision) is assessed on the **radius** of the remaining field.

**Typical values (from table 12-5)**

Type of field loss	Average loss if concentric	Visual Field score (ability)	Impairment rating (loss)
Loss of one eye	50°	90	10
Upper field loss	30°	70	30
Hemianopia	10°	50	50
Lower field loss	8°	40	60

For asymmetric losses or scotomata, use the overlays (transferred onto tracing paper) if Goldmann or Humphrey plots are available.



Alternatively, use figure 12-1 page 295 to assign 10 meridians (4 in the upper field, six in the lower field) and determine the extent of the field radius at each meridian.

For scotomata that interrupt the meridians, determine the radial extent at each meridian. Within 10 degrees of fixation, round to the nearest 2° value. Beyond 10° degrees of fixation round to the nearest 10°.

Use table 12-6 page 296 starting with the rounded peripheral field limits, subtracting for the extent of each scotomata interrupting a meridian within 10° or outside 10° of fixation. This will give ten sub-scores which need to be added together to give the visual field score for that eye.

Use table 12-9 page 304 to adjust for central scotomata.

Combine the acuity impairment and field impairment to determine the overall visual system impairment using the formula on page 304 – a simple average of the acuity and impairment ratings, expressed as a percentage).

Convert to WPI using the rule at page 306-

If the visual system impairment (VSI) is < 50%, this is equal to the WPI. If the VSI is > 50% the  $WPI = 50 + 0.7(VSI - 50)$ .

Do not adjust for near vision impairment.

## **Chapter 13 Central and peripheral nervous system**

This chapter may be used for intellectual impairment classification where appropriate.

Table 13-1 page 323 identifies where other chapters include assessments for some nervous system conditions.

Gross disorders of cortical function manifesting as developmental delay, mental handicap, impaired IQ and the childhood disorders variously named Aspergers / autism/ ADHD should be assessed using this chapter where the evidence indicates they affect the ability to skate. Such disorders will typically affect global function and not have effects only in one functional domain. The diagnostic labelling is often arbitrary and unhelpful and access to detailed psychological assessment reports is likely to be limited. Simple clinical assessment of function should be suitable in most cases to determine the impairment class.

Isolated dyslexic abnormalities which do not affect global learning and social functioning (typically individuals with a normal or high IQ but specific reading or counting deficits) will not be classified in the absence of a clinical history and objective evidence of developmental or neurological impairment.

### ADL's – adapted from table 13-2, page 323

Basic	Intermediate	Advanced
rising from bed, transferring to/from chair	Answering telephone or doorbell	Making telephone calls
Dressing	responding to questions about daily activities	Can make some plans independently
Bathing/showering	obeying simple commands	Planning and preparing a simple meal
Independent for bladder and bowel function	following simple routines	Takes own medication
personal hygiene/grooming	co-operating with others	Managing money and shopping independently
eating	Independently mobile indoors	Independently mobile outdoors in most environments
carer needed almost all of the day in own home	Carer needed for significant portion of day in own home	Carer needed for some activities outwith home and rarely needed at home
avoidance of self harm or harm to others, including self- neglect.	Could use public transport for short, familiar journeys only	Driving a car, using public transport

Classify using both the specific table for the sub-type and the Global Assessment of Function (GAF) in table 13-10, page 334.

Sub-type	Page	Table	Comments
Consciousness and awareness	327	13-4	Most will not be able to skate as this category includes encephalopathies, coma conditions, vegetative states.
Episodic loss of consciousness or awareness	328	13-5	If unable to drive or requires carer then would meet Class 1 criteria (5%).
Sleep disorders	329	13-6	Class 1 is not classifiable. If unable to drive then meets class 2 criteria.
Mental Status, Cognition and Highest Integrative Function (MSCHIF)	331	13-8	Use the upper limit for class for MSCHIF table Class 1 for those who do not achieve full range of advanced ADL's. WPI 10% Class 2 for impairment of some moderate and most advanced ADL's WPI 20%. At interview the skater will be accompanied but will be able to describe their daily routine, obey instructions and co-operate with assessment with a degree of understanding of the context. Class 3 for impairment of some basic and most moderate ADL's WPI 35%. Class 4 for those needing constant care and assistance or prompting with most simple ADL's. WPI 50%.

Sub-type	Page	Table	Comments
Aphasia or dysphasia	332	13-9	Use lowest impairment value for class but use only for isolated expressive speech. Otherwise use MSCHIF table 13.8 if there is any cognitive dysfunction.
Emotional and behavioural disorders	334	13-10	This would be appropriate table for the sequelae of head or brain injury with frontal lobe changes. Use the Global Assessment of function and also assess ADL's using the MSCHIF
Upper extremity CNS	335	13-11	Classify using the upper limb which is chapter 15.
Station and gait CNS	336	13-12	As this is particularly relevant for skating, use the highest class value.
Neurogenic bowel	337	13-13	Midpoint of class value
Neurogenic bladders	337	13-14	Midpoint of class value
Neurogenic respiratory function	338	13-16	Midpoint of class value and Upper End of Class 1 value.
Neurogenic sexual dysfunction	338	13-15	Do not classify
Dysaesthetic pain	339	13-17	
Migraine headache	342	13-18	
Trigeminal neuralgia	343	13-19	
Peripheral nerves	344	13-20	
Complex regional pain syndrome	445 to 454 540 541	15-22 to 15-26 16-14 16-15	Upper limb – use ADL's only where objective clinical findings are present, eg atrophy or muscle weakness  Lower limb - use ADL's only where objective clinical findings are present, eg atrophy or muscle weakness

Combine the different neurological impairments using the combined values chart/equation.

## Chapter 14 – Mental and Behavioural Disorders

Mental and Behavioural disorders are not classifiable under these guidelines and the principle of maximal medical improvement. The impact on skating is not objectively and consistently quantifiable. Moreover, the impact is variable day to day.

## Chapter 15 - Upper Extremities

Upper limb function is relevant to skating but some adjustment of the scales is needed to reflect the relative over-valuing of digit and thumb problems causing impaired dexterity in the Guides especially when applied to single skating. The following guidelines may be adjusted for pair skating and ice dancing in couples.

Page 419 explains the conversion factors used in the Guides:

Conversion factor of UE to WPI is 60%

UEI =90% of hand impairment

Hand impairment =40% of thumb impairment, 20% of index and mid finger and 10% of ring and little finger impairment.

Table 15-1 page 385 gives the overall definition for this chapter. Loss of an arm is given a maximum impairment of 60% whereas loss of a leg (page 495 table 16-1) is given a maximum of 40%. Also, loss of a hand is given almost the same WPI as loss of the whole arm (54% vs. 60%)

To overcome this, the relative value of upper limb impairments should be adjusted as follows:

Where there are no amputations

100% UEI = 30% WPI

Hand = maximum 5%.WPI

Elbow = maximum 50% UEI = 15% WPI

Shoulder = maximum 100% UEI = 30% WPI

The detailed tables can be used to determine within each sub-type whether the impairment is mild, moderate or severe.

Sub-type	Page	Table	Comments
Digit impairments	391	15-2	Do not classify digit impairments
Wrist and hand	395	15-3	Severe impairment of one whole hand at or below wrist= 5%
Elbow	398	15-4	Lowest class values giving a maximum UEI of 50%
Shoulder	401	15-5	Use mid point of class values giving a maximum of 100% UEI (30% WPI)
Multiple limb problems	406	157	Use functional classification to determine overall UEI and thus WPI (utilising QuickDash questionnaire). Change the score to a % UEI with score 100=30% WPI

<b>Sub-type</b>	<b>Page</b>	<b>Table</b>	<b>Comments</b>
Amputation	456	Fig 15-9	To reflect altered weight and momentum, adjust to one upper limb amputated at shoulder 40% WPI and at elbow 20 % WPI and at hand 10% WPI
Brachial plexus	434	15-20	Use functional classification to determine overall UEI and thus WPI (utilising QuickDash questionnaire). Change the score to a % UEI with score 100=30% WPI
Peripheral nerve impairment	436	15-21	Use functional classification to determine overall UEI and thus WPI (utilising QuickDash questionnaire). Change the score to a % UEI with score 100=30% WPI
Complex regional pain syndrome	453 and 454	15-24, 25 and 26	Pain is not classified. Only classifiable in the presence of objective abnormality of the limb on the day of assessment

## **Chapter 16 – Lower Extremities**

Loss of all function in one lower extremity is classified as 40% whole person impairment in the Rondinelli Guides.

In the absence of an amputation apply a weighting of 100% LEI=60% WPI.

Rate only the most impairing diagnosis at the most proximal level. As described on page 530, table 16-10, lesser and greater toe impairments can be combined with foot and ankle impairments. Impairment of the foot and ankle is converted to 70% lower extremity impairment.

<b>Sub-type</b>	<b>Page</b>	<b>Table</b>	<b>Comments</b>
Foot and ankle	501	16-2	Use highest impairment value for class
Knee	509	16-3	Use highest impairment value for class
Hip	513	16-3	Use highest impairment value for class
Peripheral nerve impairment	534	16-12	Use highest impairment value for class
Complex regional pain syndrome	541	16-15	Use highest impairment for class using objective diagnostic criteria in table 16-13 and not rating on pain symptoms only
Amputation	542	16-16	Use highest impairment value for class

<b>Sub-type</b>	<b>Page</b>	<b>Table</b>	<b>Comments</b>
Motion impairments	549	16-18 to 16-25	Use these if the diagnosis-based impairment is not suitable. Contractures such as those with hemiplegia may be best classified by this route.
Complex regional pain syndrome	539, 540, 541	16-13, 14, 15	Pain is not classified. Only classifiable in the presence of objective abnormality of the limb on the day of assessment

## **Chapter 17 – Spine and Pelvis**

Good spinal function at all levels is necessary for skating. For this chapter, use the highest impairment in each class.

Table 17-1 page 559 gives the WPI for different spinal areas: maximum WPI for neck is 30%, thoracic spine 22%, lumbar spine 33% and pelvis 16%.

If there is documented cauda equine syndrome or spinal cord injury with findings of neurogenic bowel or bladder etc., an additional impairment calculation is appropriate using chapter 13.

Common degenerative conditions are not objectively assessable so cannot be rated, but neurological impairment, sciatica etc. are ratable under chapters 13, 15 and 16.

Imaging studies in adults without back pain will show that 30% have a herniated disk, more than 50% have disk bulges, 7% have spondylolysis and 3% have spondylolisthesis (page 577). For this reason these require careful interpretation such that clinical history and findings are considered first, with imaging studies usefully contributing to confirmation of diagnosis.

Table 17-8 and figure 17-4 page 578 summarise the typical deficits of radiculopathies.

Clinical findings and imaging studies must be consistent. As congenital disorders such as spina bifida and developmental disorders such as kyphoscoliosis are not ratable, use the appropriate table for impairment of motion segment(s).

<b>Sub-type</b>	<b>Page</b>	<b>Table</b>	<b>Comments</b>
Cervical	564	17-2	Use highest value for class.
Thoracic	567	17-3	Use highest value for class.
Lumbar	570	17-4	Use highest value for class.
Pelvis	593	17-11	Use highest value for class.

**9. FORMS FOR CLASSIFICATION**  
**SKATER'S PHYSICIAN REPORTING FORMS**



## PHYSICIAN REPORTING OF CARDIOVASCULAR SYSTEM

This form provides the criteria for evaluating impairment of the Cardiovascular system based on the Classification Code's recommended use of Chapter 4 of the AMA Guides for Evaluation of Permanent Impairment.

The appropriate section(s) of the form **MUST** be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.

Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.

If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.

SKATER AND PHYSICIAN INFORMATION	
NAME OF SKATER	
NATIONALITY OF SKATER	
IDENTITY (NATIONAL IDENTITY NUMBER / PASSPORT) OF SKATER	
DATE OF BIRTH OF SKATER	
NAME OF PHYSICIAN	
NATIONALITY OF PHYSICIAN	
IDENTITY OF PHYSICIAN (NATIONAL PHYSICIAN IDENTITY NUMBER AND PASSPORT WHERE RELEVANT)	

**In regard to this Skater's Cardiovascular functioning and Impairment, Please provide information on;**



**DIAGNOSIS**

**RELEVANT CLINICAL HISTORY (Please give full details of any medical and surgical treatment, investigation and imaging results and the dose, route of administration and frequency of any medication)**

**CURRENT SYMPTOMS/ TREATMENT (Please give full details of any residual clinical signs and symptoms and the dose, route of administration and frequency of any medication)**

**PHYSICAL EXAMINATION/FINDINGS**

**ASSESSMENT of FUNCTIONAL CLASSIFICATION (IDENTIFY SKATER'S FUNCTIONALITY) PLEASE CIRCLE WHICH APPLIES**

Class	Function of Patients
I	Patients with no limitations of activities; they suffer no symptoms from ordinary activities
II	Patients with slight, mild limitations of activities; they are comfortable with rest or with mild exertion.
III	Patients with marked limitations of activities; they are comfortable with rest or with mild exertion.
IV	Patients who should be at complete rest, confined to bed or chair; any physical activity brings on discomfort and symptoms occur at rest. (Pain in muscles of arms or legs in use)

**Blood Pressure:** \_\_\_\_\_

**Heart Rate:** \_\_\_\_\_

**ABPI (if applicable) :** \_\_\_\_\_

**Intermittent Claudication Distance (if applicable):** \_\_\_\_\_

**Append the relevant diagnostic reports to this form. These may include;**

- Doppler Echocardiogram results including Left Ventricular Ejection Fraction (LVEF).
- Other imaging results such as angiogram, cardiac catheterisation (inclusion of ventricular pressures), X-Ray, CT or MRI.
- Electrocardiogram (ECG) results
- B-type natriuretic peptide (BNP) levels or creatinine levels,
- Arterial or venous Doppler study.
- Cardiopulmonary exercise testing investigation results (Vo<sub>2</sub> max or Maximum Oxygen Consumption (METS)) include protocol followed
- Details of any surgical treatments
- Myocardial perfusion scan
- Stress echocardiogram
- Exercise stress testing



## PHYSICIAN REPORTING OF PULMONARY SYSTEM

This form provides the criteria for evaluating impairment of the Pulmonary System based on the Classification Code's recommended use of Chapter 5 of the AMA Guides for Evaluation of Permanent Impairment.

**The appropriate section(s) of the form MUST be completed by your physician and/or specialist in its entirety if an impairment entitlement is to be granted for the skating competition.**

**Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.**

**If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.**

SKATER AND PHYSICIAN INFORMATION	
NAME OF SKATER	
NATIONALITY OF SKATER	
IDENTITY (NATIONAL IDENTITY NUMBER / PASSPORT) OF SKATER	
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NAME OF PHYSICIAN	
NATIONALITY OF PHYSICIAN	
IDENTITY OF PHYSICIAN (NATIONAL PHYSICIAN IDENTITY NUMBER AND PASSPORT WHERE RELEVANT)	

**IN REGARD TO THIS SKATER'S PULMONARY FUNCTIONING AND IMPAIRMENT, PLEASE PROVIDE INFORMATION ON:**

**DIAGNOSIS**

**RELEVANT CLINICAL HISTORY AND TREATMENT** (please give full details of any medical and surgical treatment, investigation and imaging results and the dose, route of administration and frequency of any medication).

**CURRENT SYMPTOMS – PLEASE ALSO PROVIDE INFORMATION ON RESIDUAL CLINICAL SIGNS AND SYMPTOMS**

**PHYSICAL EXAMINATION/FINDINGS**

**Please indicate which applies to skater**

<b>Class</b>	<b>Function of Patients</b>
Mild	Do you have to walk more slowly on level ground than people of your age because of breathlessness?
Moderate	Do you have to stop for breath when walking at your own pace on level ground?
Severe	Do you ever have to stop for breath after walking about 90 m (100 yd) or for a few minutes on level ground?
Very Severe	Are you too breathless to leave the house, or breathless on dressing or undressing?
Table 5-1;	

## ***TREATMENT***

### **Spirometry results (after correction by medication)**

**FEV<sub>1</sub>** \_\_\_\_\_

**FVC** \_\_\_\_\_

**FEV<sub>1</sub>/FVC (%)** \_\_\_\_\_

*These results are mandatory as they are essential for correct classification.*

**Append the relevant supportive diagnostic reports to this form. These may include;**

- Spirometry results – FEV<sub>1</sub>, FVC AND FVC/FEV<sub>1</sub> results – MANDATORY.
- Pulmonary function testing
- Results of Cardiopulmonary exercise testing (Vo<sub>2</sub> max or Maximum Oxygen Consumption (METS)) or Diffusion Capacity for Carbon Monoxide (DLco).
- Details of any relevant imaging results such as X-ray, air bronchogram, CT, MRI
- Details of any surgical treatment.



<p><b>PHYSICIAN REPORTING OF DIGESTIVE SYSTEM</b></p>
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This form provides the criteria for evaluating impairment of the Digestive system based on the Classification Code's recommended use of Chapter 6 of the AMA Guides for Evaluation of Permanent Impairment.

The appropriate section(s) of the form **MUST** be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.

Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.

If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.

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**FOR EACH ABNORMALITY or AFFECTED COMPONENT OF DIGESTIVE SYSTEM PROVIDE INFORMATION ON**

***DIAGNOSIS***

***TREATMENT (Please give full details of medical and surgical treatment, laboratory findings, dose, route of administration and frequency of any medication)***

***DESCRIPTION of RESIDUAL CLINICAL SYMPTOMS, SIGNS or STOMAS***

**Append the relevant diagnostic reports to this form. These may include**

1. Imaging results such as ultrasonograms, barium studies, ERCP, MRCP, CT, MRI .
2. Height and weight.
3. Details of endoscopic investigations or treatments.
4. Details of any surgical treatment .
5. Blood urea, electrolytes, liver function tests, hemoglobin, prothrombin time, other biochemical or hematological investigations
6. Presence of any stoma, fistula or surgical anastomosis.
7. Presence of any post-surgical or other hernia or fistula.
8. Need for parenteral or supplemented nutrition.



## PHYSICIAN REPORTING OF URINARY SYSTEM

This form provides the criteria for evaluating impairment of the Urinary System based on the Classification Code's recommended use of Chapter 7 of the AMA Guides for Evaluation of Permanent Impairment.

The appropriate section(s) of the form **MUST** be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.

Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.

If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.

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**DIAGNOSIS**

**TREATMENT** (Please give full details of medical and surgical treatment, laboratory findings, dose, route of administration and frequency of any medication)

**DESCRIPTION of RESIDUAL CLINICAL SYMPTOMS, SIGNS or STOMAS**

**Append the relevant diagnostic reports to this form. These may include**

1. Imaging results such as ultrasonograms. CT, MRI .
2. Renal biopsy findings.
3. Details of cystoscopic investigations, treatments or cystograms.
4. Details of any surgical treatment .
5. Blood urea, electrolytes, creatinine clearance, GFR, hemoglobin, other biochemical or hematological investigations.
6. Presence of any stoma, fistula or surgical anastomosis.
7. Presence of any post-surgical or other hernia or fistula.
8. Frequency of peritoneal or hemodialysis.



## PHYSICIAN REPORTING OF SKIN

This form provides the criteria for evaluating impairment of the Skin system based on the Classification Code's recommended use of Chapter 8 of the AMA Guides for Evaluation of Permanent Impairment.

The appropriate section(s) of the form **MUST** be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.

Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.

If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.

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**DIAGNOSIS**

**TREATMENT** *(Please give full details of medical and surgical treatment, dose, route of administration and frequency of any medication)*

**DESCRIPTION of RESIDUAL CLINICAL SYMPTOMS OR SIGNS**

**Append the relevant diagnostic reports to this form. These may include:**

1. Sites(s) and extent of skin disease.
2. Details of inpatient treatments, scars, grafts or disfigurements.
3. Patch or other diagnostic tests.
4. Impact upon ordinary daily activities.



## PHYSICIAN REPORTING OF HAEMATOLOGICAL DISEASE

This form provides the criteria for evaluating impairment of the hematopoietic system based on the Classification Code's recommended use of Chapter 9 of the AMA Guides for Evaluation of Permanent Impairment.

**The appropriate section(s) of the form MUST be completed by the skater's own physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.**

If the necessary information is missing, you may be awarded only the minimum 5% impairment compensation providing the minimal impairment criteria are established.

<b>SKATER AND PHYSICIAN INFORMATION</b>	
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<b>IDENTITY OF PHYSICIAN (NATIONAL PHYSICIAN IDENTITY NUMBER AND PASSPORT WHERE RELEVANT)</b>	

**DIAGNOSIS**

  
  
  

**TREATMENT** *(Please give full details of dose, route of administration and frequency of any medication and / or transfusions)*

--

**Append the relevant laboratory reports to this form. These may include**

1. Full blood count including platelet and differential white cell counts
2. Bone and /or other tissue biopsy
3. Coagulation studies
4. Serology
5. Lymphocyte subset counts
6. Hemoglobin electrophoresis

**If patient is receiving relevant treatment eg transfusions, please indicate the timing of the blood reports in relation to such treatment**

The following table must be completed to document clinical history. **Place a mark in the appropriate column**

	No	Yes	Occasionally	Frequently	Constantly
Symptoms of anemia					
Recurrent infections					
Antibiotic usage					
Bleeding episodes					

**Number of times hospitalised in past year for treatment of infection?**

**Number of times hospitalised in past year for treatment of bleeding episode?**

**Please indicate with “yes” which one of the following activity levels applies**

**Fully active \_\_\_\_\_ Restricted in physically strenuous activity \_\_\_\_\_**



**PHYSICIAN REPORTING  
OF  
ENDOCRINE DISEASE**

This form provides the criteria for evaluating impairment of the Endocrine system based on the Classification Code’s recommended use of Chapter 10 of the AMA Guides for Evaluation of Permanent Impairment.

The appropriate section(s) of the form **MUST** be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.

Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.

If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.

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<p><b>DIAGNOSIS</b></p> <p><b>TREATMENT</b> (Please give full details of dose, route of administration and frequency of any medication)</p>
---

<b>DESCRIPTION of RESIDUAL CLINICAL SYMPTOMS</b>
--

**Append the relevant diagnostic reports to this form. These may include**

1. Endocrine test results including dynamic function testing
2. Serum/plasma calcium, phosphorus, glucose, HbA1c, lipids
3. Plasma urine and serum osmolality
4. Bone densitometry
5. Imaging results
6. Radioisotope scans
7. Fine needle aspiration / biopsy results



## PHYSICIAN REPORTING OF EAR, NOSE, THROAT AND RELATED STRUCTURES

This form provides the criteria for evaluating impairment of the ear, nose, throat and related structures using Chapter 11 of the AMA Guides for Evaluation of Permanent Impairment.

**The appropriate section(s) of the form MUST be completed by your physician/audiologist/specialist in its entirety if an impairment entitlement is to be granted for the skating competition.**

If the necessary information is missing, you may be awarded only the minimum 5% impairment compensation providing the minimal impairment criteria are established.

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### ASSESSMENT OF HEARING

Criteria for evaluating hearing loss are established through hearing threshold testing, **measured in each ear separately and both ears together with audiometry using the American National Standards Institute (ANSI) standard S3.6-1996.** The binaural hearing impairment percentage is based



on the severity of the hearing loss which account for changes in the ability to perform activity of daily living.

**DIAGNOSIS- CAUSE FOR HEARING IMPAIRMENT**

No Correction is made for prebycusis or age

**Pure Tone Audiogram**

**Hearing Level at:**

500 Hz \_\_\_\_\_ Left \_\_\_\_\_ Right

1000 Hz \_\_\_\_\_ Left \_\_\_\_\_ Right

2000 Hz \_\_\_\_\_ Left \_\_\_\_\_ Right

3000 Hz \_\_\_\_\_ Left \_\_\_\_\_ Right

## ASSESSMENT OF EQUILIBRIUM

In order to determine impairment based on disequilibrium, a **specific diagnosis pertaining to the cause is required** (i.e. visual, kinesthetic, vestibular, CNS) and the condition must be considered stable or have reached maximum medical improvement.

**This form should be used to determine disturbance in equilibrium due to vestibular disorders only.**

Subjective complaint and/or clinical diagnosis alone is NOT sufficient for purpose of assigning classification for impaired skating.

**Objective assessment is required.**

### ***DIAGNOSIS/CAUSE OF THE DISEQUILIBRIUM:***

**Append the results of the following objective equilibrium assessment (if available) to this form:**

1. Electronystagmography (ENG) - must be done without influence of Central Nervous System influencing medications.
2. Computerized Dynamic Posturography (CDP)
3. Evoked Vestibular Response (EVR)
4. Caloric Responses

The following table must be completed to document the subjective complaint and **objective clinical examination findings**. **Place a mark in the appropriate column to identify the presence or absence of symptoms and the frequency of severity.**

	No	Yes	Occasionally	Frequently	Constantly
Nausea					
Vomiting					
Headache					
Immobility					
Unsteady Gait					
Ataxia					
Hearing Loss					
Tinnitus					
Light-headed					
Dizziness					
Rhomberg Test Positive					
Nystagmus					
Needs help with ADL's					
Other (describe)					

## AIRWAY OBSTRUCTION DISORDERS

Classification of impairment to the **upper airway** may only be accomplished after successful treatment of contributing factors (acid reflux, post-nasal drainage, asthma). Lower airway disorders are assessed by determining impairment to the pulmonary system.

Subjective complaint and/or clinical diagnosis alone is NOT sufficient for purpose of assigning classification for impaired skating.

**Objective assessment is required.**

### DIAGNOSIS/CAUSE OF AIRWAY OBSTRUCTION:

**Append the results of the following objective upper airway assessment (if available) to this form:**

1. Trans-nasal pharyngolaryngoscopy
2. Tracheoscopy
3. Imaging studies (i.e. sinus CT)
4. Pulmonary function tests

The following table must be completed to document the subjective complaint and **objective clinical examination findings**. **Place a mark in the appropriate column to identify the presence or absence of symptoms and the frequency of severity.**

	No	Yes	Occasionally	Frequently	Constantly
No complaint of dyspnea					
Dyspnea with intense effort					
Dyspnea with minimal effort					
Dyspnea at rest					
Stridor					
Laryngospasm/vocal cord dysfunction					
Requires assistance with ADL					
Tracheostomy/stoma					
Other (describe):					



## PHYSICIAN REPORTING OF VISUAL SYSTEM

This form provides the criteria for evaluating impairment of the Visual system based on the Classification Code's recommended use of Chapter 12 of the AMA Guides for Evaluation of Permanent Impairment.

The appropriate section(s) of the form **MUST** be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.

Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.

If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.

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Impairment of the visual system does not consider anatomic changes to any component of the visual system. Impairment classification considers only the functional consequences to vision-related activities of daily living that is the result of changes to visual acuity and visual fields.

For the purpose of classification, both **visual acuity (with best correction) and visual fields must be monocularly and binocularly recorded** by an ophthalmologist or optometrist.

**DIAGNOSIS/CAUSE OF VISUAL LOSS:**

**Please check all that apply to the skater you are assessing:**

- |  |  |
|--|--|
| <input type="checkbox"/> Eye movement disorder       | <input type="checkbox"/> Glare Sensitivity     |
| <input type="checkbox"/> Contrast sensitivity        | <input type="checkbox"/> Night vision deficits |
| <input type="checkbox"/> Color-blindness             | <input type="checkbox"/> Stereopsis            |
| <input type="checkbox"/> Photophobia                 | <input type="checkbox"/> Diplopia              |
| <input type="checkbox"/> Dark adaptation             |  |
| <input type="checkbox"/> Prosthesis ( LEFT / RIGHT ) |  |

**VISUAL ACUITY:** (may be recorded in US notation, i.e. 20/20; or 1m notation, i.e. 1/1)

- **acuity must be measured under realistic daily living conditions** with no alteration to illumination

- visual reading acuity is not required and will not be considered for purpose of classification of impairment for speed or figure skating

Best **UNCORRECTED** acuity:

Left Eye/ OS: \_\_\_\_\_  
Right Eye/OD: \_\_\_\_\_  
Binocular/OU: \_\_\_\_\_

Best **CORRECTED** acuity:

Left Eye/OS: \_\_\_\_\_  
Right Eye/OD: \_\_\_\_\_  
Binocular/OU: \_\_\_\_\_

Does the skater have a total absence of light perception in the LEFT/OS eye? **YES / NO**

Does the skater have a total absence of light perception in the RIGHT/OD eye? **YES / NO**

Does the skater train/compete with corrective lenses? **YES / NO**

**VISUAL FIELDS:**

**Formal assessment of binocular visual fields to the 60° radius (i.e. Goldman or Humphrey field tests) must be appended** for a complete compensation award assessment.

If visual fields are not appended, it will be assumed visual fields are normal.



**PHYSICIAN REPORTING  
OF CENTRAL AND  
PERIPHERAL NERVOUS  
SYSTEM  
(May include Intellectual  
impairment)**

This form provides the criteria for evaluating impairment of the Central and Peripheral Nervous system based on the Classification Code’s recommended use of Chapter 13 of the AMA Guides for Evaluation of Permanent Impairment.

The appropriate section(s) of the form **MUST** be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.

Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.

If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.

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**DIAGNOSIS****TREATMENT (Please give full details of diagnosis, investigation findings, dose, route of administration and frequency of any medication)****DESCRIPTION OF IMPACT ON ACTIVITIES OF DAILY LIVING (see below also)****ASSESSMENT OF ADL's AND CARE NEEDS (TICK THOSE ACHIEVED)**

<b>Simple</b>	<b>Intermediate</b>	<b>Advanced</b>
rises from bed, transfers to/from chair	obeys simple instructions	Takes own medication
Dresses	responds to questions about daily activities	Can make some plans independently
Baths, showers	Answers phone or doorbell	Makes phone calls, sends texts or uses IT
Eat and drinks without assistance	Warms prepared food, makes tea or coffee following instructions or a routine	Plans and prepares a simple meal if ingredients available
Performs personal hygiene/grooming tasks	follows simple routines, co-operating with others	Manages money and shops independently
Independent for bladder and bowel function	Independently mobile indoors	Independently mobile outdoors in most environments
avoids self harm or harm to others, including self-neglect.	Could use public transport for short, familiar journeys only	Drives a car, uses public transport
carer needed almost all of the day in own home	Carer needed for significant portion of day in own home	Carer needed for some activities outwith home and rarely needed at home
Additional notes		

**Append the relevant diagnostic, clinical or functional reports to this form. These may include**

1. CT, MRI , EEG, nerve conduction studies or other clinical investigations.
2. Information on frequency and duration of loss of consciousness or seizure activity.
3. Evaluations of functional capacity such as ability to dress, eat, bath, toilet, mobilise independently indoors, avoiding harm to self or others. Ability to obey commands, phone, use IT or text, prepare food, shop. Ability to mobilise outdoors, drive or use public transport.
4. Any need for carer in the home or outside.
5. Impact upon bowel, bladder or respiratory function





## PHYSICIAN REPORTING OF UPPER EXTREMITIES

This form provides the criteria for evaluating impairment of the Upper Extremities based on the Classification Code's recommended use of Chapter 15 of the AMA Guides for Evaluation of Permanent Impairment.

**The appropriate section(s) of the form MUST be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.**

**Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.**

**If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.**

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Where an upper limb impairment is immediately obvious to the classifier such as an amputation no supporting medical evidence is usually required. However if a competitor wishes to submit any supporting evidence relevant to the impairment this may be considered in the classification process.

All other impairments require supporting medical evidence in the form of medical correspondence detailing:-

- a) the impairment(s) competitors wish to be considered for classification,
- b) date of onset of impairment,
- c) any treatment to date,
- d) any proposed treatment (including dates if known) and
- e) whether the impairment is thought to be stable or progressive.

In the case of a stable impairment supporting medical evidence dated no more than a year from the proposed date of classification will be considered. In the case of a progressive impairment it is in the interests of the competitor to present the most recent supporting medical evidence.

In cases of neurological impairment nerve conduction studies can be submitted.

Radiological images e.g. X- rays or MRI are not required but copies of radiology reports which define the impairment should be submitted.

If a competitor usually wears a prosthesis for skating then competitors are advised to bring the prosthesis to the event in order that it may be considered during the classification process.

All competitors are required to submit the completed first page/ module of the Mini [DASH](#) questionnaire for initial assessment of impairment and at any point thereafter if a change of impairment is observed.

<http://www.dash.iwh.on.ca/>



## PHYSICIAN REPORTING OF LOWER EXTREMITIES

This form provides the criteria for evaluating impairment of the lower extremities based on the Classification Code's recommended use of Chapter 16 of the AMA Guides for Evaluation of Permanent Impairment.

**The appropriate section(s) of the form MUST be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.**

**Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.**

**If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.**

SKATER AND PHYSICIAN INFORMATION	
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Where a lower limb impairment is immediately obvious to the classifier such as an amputation no supporting medical evidence is usually required. However if a competitor wishes to submit any supporting evidence relevant to the impairment this may be considered in the classification process.

All other impairments require supporting medical evidence in the form of

medical correspondence detailing:-

- a) the impairment(s) competitors wish to be considered for classification,
- b) date of onset of impairment,
- c) any treatment to date,
- d) any proposed treatment (including dates if known) and
- e) whether the impairment is thought to be stable or progressive.

In the case of a stable impairment supporting medical evidence dated no more than a year from the proposed date of classification will be considered. In the case of a progressive impairment it is in the interests of the competitor to present the most recent supporting medical evidence.

In cases of neurological impairment nerve conduction studies can be submitted.

Radiological images e.g. X- rays or MRI are not required but copies of radiology reports which define the impairment should be submitted.



## PHYSICIAN REPORTING OF SPINE AND PELVIS

This form provides the criteria for evaluating impairment of the Spine and Pelvis using Chapter 17 of the AMA Guides for Evaluation of Permanent Impairment.

**The appropriate section(s) of the form MUST be completed by your physician/ specialist in its entirety if an impairment entitlement is to be granted for the skating competition.**

**Supporting documentation in the form of relevant laboratory, imaging and/or other reports must be appended.**

**If the necessary information to determine classification is missing, the minimum 5% impairment compensation may be awarded providing the minimum functional impairment is established.**

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A clinical assessment of spine and or pelvic impairment will be made on the day of initial impairment classification and on any appropriate occasion thereafter where a review of impairment is deemed necessary such as when a change in impairment is observed.

Supporting medical evidence of an impairment is essential to help define the level and should be submitted in the form of medical correspondence detailing:-

- a) the impairment(s) competitors wish to be considered for classification,
- b) date of onset of impairment,
- c) any treatment to date,
- d) any proposed treatment (including dates if known) and
- e) whether the impairment is thought to be stable or progressive.
- f) In the case of spinal impairment the level(s) of impairment should be detailed e.g. Vertebral/disc location (cervical, thoracic, lumbar or sacral) and number of vertebrae/discs affected.

In the case of a stable impairment supporting medical evidence dated no more than a year from the proposed date of classification will be considered. In the case of a progressive impairment it is in the interests of the competitor to present the most recent supporting medical evidence.

In cases of neurological impairment nerve conduction studies can be submitted.

Radiological images e.g. X- rays or MRI are not required but copies of radiology reports which define the impairment should be submitted.

## **10. MEDICAL AND CLASSIFICATION CASE REVIEWS**

**These will develop as the classification system is implemented and will include a summary of and disability adjustments given and commentary for each case.**