UNIVERSITY OF ILLINOIS
AT URBANA-CHAMPAIGN

**Department of Kinesiology & Community Health**

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**MEDICAL RELEASE (control group)**

To the physician of_____D.O.B._____

Your patient has expressed interested in participating in a study investigating the effects of a training protocol eye saccade performance. Outcome measures include eye saccade latency prior to an involuntary/voluntary saccade, saccade duration, and saccade amplitude. The protocol involves a large TV that will display targets arranged in circles of varying sizes meant to train eye movements up to 50 degrees of the participant's field of view. Participants will be asked to make approximately 120 saccades over the course of 30 min. There will be a total of eight training sessions and two assessment sessions. As an initial measure, we screen each applicant prior to training. We ask for your assistance in approving your patient's participation in the study. Please complete the approval form if, in your medical judgment, this individual has no contraindications to participation in this study. If you have any questions please do not hesitate to contact the principal investigator in the study, [redacted]

Thank you for your help.

**To be completed by the participant**

Date_____

Name_____

Address_____

City/State/Zip_____

Phone(_____)_____E-mail_____

Date of Birth(MM/DD/YYYY)_____

Primary Diagnosis_____

Date of Diagnosis(MM/DD/YYYY)_____

Emergency Contact Name_____

Relationship_____ Phone #(_____)_____

Do you have any allergies? (please specify) _____

Have you ever been diagnosed with the following?

Diabetes(Y/N)____(Insulin?____) Parkinson's disease____Hypertension_____

Pulmonary Disease____20/20 or Corrected Vision____ Retinal Disease(specify)_____

Glaucoma_____ Ischemic Optic Neuropathy_____ Pseudoxfoliation Syndrome_____

Ocular Surgery_____ Ocular Trauma_____ Cataracts_____ Orbital myostisis_____ Hoehn and Yahr score_____

Other (explain)_____

Are you receiving outpatient therapy? (Y/N)_____

Have you undergone brain surgery? (Y/N) _____

Surgeries/Dates_____

_____

Medications (List)

_____

_____

_____

_____

Change in use of disease modifying therapy in the last 6 months? (Y/N)_____

By signing this document, I give permission to have my physician mail a medical release form to [redacted]

Signature_____Date_____

**To be completed by the participant's physician:**

Participant's Name_____

Diagnosis(List All)_____

Mobility Impairments

_____

_____

Height_____ Weight_____ Pulse_____ BP_____ Sex_____

| Physical Exam | Normal | Abnormal | Explanation of Abnormalities |
|---|---|---|---|
| Head/Neck | _____ | _____ | _____ |
| Eyes/Vision | _____ | _____ | _____ |
| Ears/Hearing | _____ | _____ | _____ |
| Heart/Lung | _____ | _____ | _____ |
| G.U. | _____ | _____ | _____ |
| C.N.S. | _____ | _____ | _____ |
| Skin | _____ | _____ | _____ |

Dates of hospitalization over last two years with admitting diagnoses:

_____

_____

Significant "ABNORMAL TEST" (EKG/XRAY/LAB):_____

Medications

Has there been a change in use of disease modifying therapy in the past 6 months

YES_____NO_____

If yes, specify_____

Initiation of medications that influence walking/mobility/coordination in the past 30 days?

YES_____NO_____

Approval for participation: YES_____NO_____

Comments/Restrictions:_____

_____

_____

_____

Address:_____

City:_____State:_____ZIP:_____

Physician's Signature:_____Date:_____

Thank you for your time to read this summary and evaluate your patient's status for participation in this study.

Permission to release patient information to the [redacted] can be found on page 6.

MAIL TO:

[redacted]

THANK YOU FOR YOUR PARTICIPATION.