CAF PRE-COMPETITION CARDIAC ASSESSMENT + (PCCA +)

PLAYER:

SURNAME:

FIRST NAME:

DATE OF BIRTH: **(DAY / MONTH / YEAR)**

NATIONAL TEAM:

LOCAL CLUB:

COUNTRY OF CLUB:

1. Competition History

Position on the field ☐ goalkeeper ☐ defender ☐ midfielder ☐ striker

Dominant leg ☐ left ☐ right ☐
both

Number of matches in the last 12 months _______________

2. Medical History

2.1 Present and Past complaints

General	**no**	yes, within **the last 4 weeks**	yes, **prior** to the last 4 weeks
Flu-like symptoms	☐	☐	
Infections (esp. viral)	☐	☐	☐
Rheumatic fever	☐	☐	☐
Heat illness	☐	☐	☐
Concussion	☐	☐	☐
Allergies to food, insects	☐	☐	☐
Allergies to drugs	☐	☐	☐
Heart and lung	**no**	within the last 4 weeks **at rest……during/after exercise**	prior to last 4 weeks **at rest…during/after exercise**
Chest pain or tightness	☐	☐ ☐	☐ ☐
Shortness of breath	☐	☐ ☐	☐ ☐
Asthma	☐	☐ ☐	☐ ☐
Palpitations	☐	☐ ☐	☐ ☐
Dizziness	☐	☐ ☐	☐ ☐
Syncope	☐	☐ ☐	☐ ☐
	no	yes, within the **last 4 weeks**	yes, **prior** to the last 4 weeks
Abnormal lipid profile	☐	☐	☐
Seizures, epilepsy	☐	☐	☐
Advised to give up sport	☐	☐	☐
More quickly tired than team mates	☐	☐	☐
Diarrhoea illness	☐	☐	☐

Additional notes: ____

Additional Specific COVID-19 Personal History and Symptoms

Have you been tested positive to Coronavirus (Covid-19) before? (PCR only) Yes ☐ No ☐

If yes, have you ever had a Chest CT Scan with appearance of COVID-19 pneumonia characterized by ground-glass opacities? (Please specify the date) Yes ☐ No ☐
Date ________________________________

If yes, have you ever had some of the following signs and symptoms?

- Fever within the past four (04) days Yes ☐ No ☐
- Dry cough Yes ☐ No ☐
- Tiredness Yes ☐ No ☐
- Aches and pains Yes ☐ No ☐
- Muscular weakness Yes ☐ No ☐
- Sore throat Yes ☐ No ☐
- Vomiting or Diarrhea Yes ☐ No ☐
- Loss of taste or smell Yes ☐ No ☐
- Difficulty breathing or shortness of breath Yes ☐ No ☐

2.2 Family history (male relatives < 55 years, female relatives < 65 years)

	no	father	mother	sibling	other
Sudden cardiac death	☐	☐	☐	☐	☐
Sudden infant death	☐		☐	☐	
Coronary heart disease	☐ ☐	☐	☐	☐	
Hypertension	☐ ☐	☐	☐	☐	
Recurrent syncope	☐ ☐	☐	☐	☐	
Heart transplantation	☐ ☐	☐	☐	☐	
Heart surgery	☐ ☐	☐	☐	☐	
Pacemaker/Defibrillator	☐ ☐	☐	☐	☐	
Marfan syndrome	☐ ☐	☐	☐	☐	
Unexplained drowning	☐ ☐	☐	☐	☐	
Unexplained car accident	☐ ☐	☐	☐	☐	
Stroke	☐ ☐	☐	☐	☐	
Diabetes	☐ ☐	☐	☐	☐	
Cancer	☐ ☐	☐	☐	☐	
Others (arthritis etc.)	☐ ☐	☐	☐	☐	

2.3 Routine medication within last 12 months

	no	yes
Non-steroidal anti inflammatory drugs	☐	☐
Asthma medication	☐	☐
Antihypertensive drugs	☐	☐
Lipid lowering drugs	☐	☐
Antidiabetic drugs	☐	☐
Psychotropic drugs	☐	☐

Other ______________________________ ☐ ☐

3. General Physical Examination

Height ______ cm/______ inch   Weight: ______kg/______ lbs

Thyroid gland	☐ normal	☐ abnormal
Lymph nodes/spleen	☐ normal	☐ abnormal

Lungs

Percussion	☐ normal	☐ abnormal
Breath sounds	☐ normal	☐ abnormal

Abdomen

Palpation	☐ normal	☐ abnormal

Marfan Criteria

☐ no   ☐ yes, please specify:
- ☐ chest deformities
- ☐ long arms and legs
- ☐ flat footedness
- ☐ scoliosis
- ☐ lens dislocation
- ☐ other:

4. Cardiovascular System

Rhythm	☐ normal	☐ arrhythmic

Heart sounds   ☐ normal   ☐ abnormal, please specify:
- ☐ split
- ☐ paradoxically split
- ☐ 3rd heart sound
- ☐ 4th heart sound

Heart murmurs   ☐ no   ☐ yes, please specify:
- ☐ systolic - intensity: ____/6
- ☐ diastolic - intensity: ____/6
- ☐ clicks

☐ changes during Valsalva manoeuvre
☐ changes when abruptly stands up

Peripheral oedema	☐ no	☐ yes
Jugular veins (45° position)	☐ normal	☐ abnormal
Hepato-jugular reflux	☐ no	☐ yes

Blood vessels

Peripheral pulses	☐ palpable	☐ not palpable
Delay in femoral pulses	☐ no	☐ yes
Vascular bruits	☐ no	☐ yes
Varicose veins	☐ no	☐ yes

Heart rate after 5 Minutes rest

_______ /min

Blood Pressure in Supine Position after 5 minutes rest

Right arm ___ / ___ mmHg

Left arm ___ / ___ mmHg

4.1 12-LEAD RESTING ECG* IN SUPINE POSITION AFTER FIVE MINUTES' REST
*** PLEASE RECORD AND STORE ECG FOR CLINICAL AND LEGAL ISSUES.**

PLEASE PERFORM AND ASSESS THE 12-LEAD ECG ACCORDING TO THE CURRENT INTERNATIONAL (SEATTLE) CRITERIA². CONSULT A CARDIOLOGIST IN CASE OF ANY DOUBT.

REQUIRED PARAMETERS ARE MISSING OR INCORRECT.

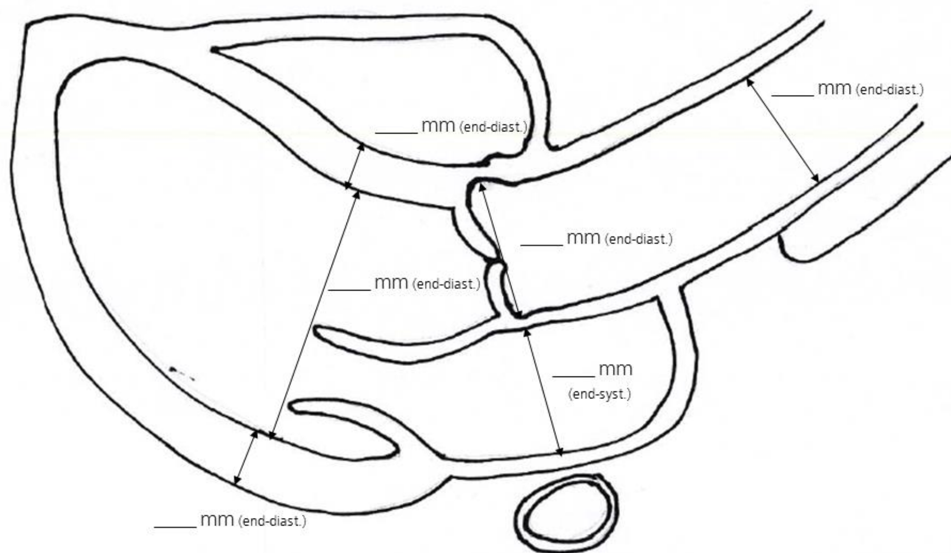
SUMMARY ASSESSMENT OF ECG ☐ **NORMAL** ☐ **ABNORMAL, PLEASE SPECIFY:**

____

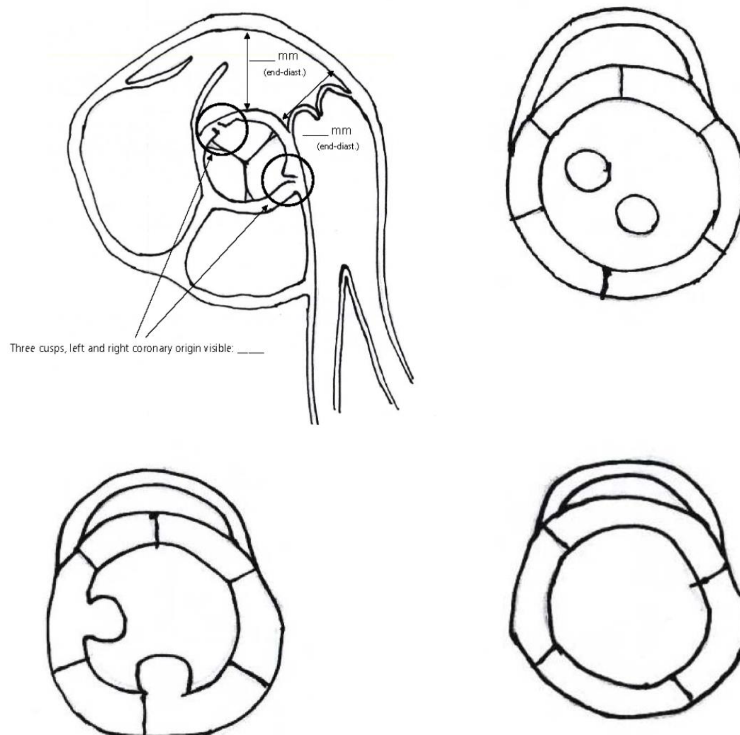
4.2 If 12-lead resting ECG abnormal, heart ultrasound

*** Please record and store Echo loops for clinical and legal issues.**
The echocardiography should be performed by a designated physician and expert in echocardiography with particular experience in the assessment of athletes. The examination should be based on the internationally accepted echo guidelines in "non-athletes"[3]. However, as athletes may exhibit physiologic deviations from conventional "ranges of normal", we also refer to corresponding specific sports cardiology literature.

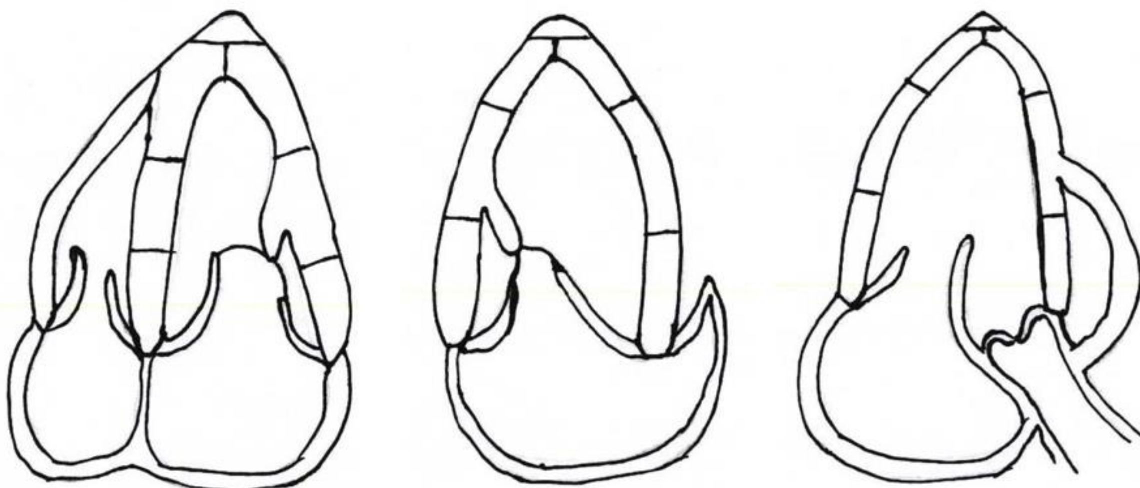
Parasternal long axis:



PARASTERNAL SHORT AXIS (INCL. CORONARY ARTERY ORIGIN):



APICAL VIEWS:



LEFT VENTRICLE:

- **DIMENSIONS:** NORMAL ☐ ABNORMAL ☐

- LVEDV: _______ML
- LVEDVI: _______ML

- Systolic function: Normal ☐ Abnormal ☐
  - LVEF: ________ %

- Diastolic function: Normal ☐ Abnormal ☐

Right ventricle:
- Dimensions: Normal ☐ Abnormal ☐
- Function: Normal ☐ Abnormal ☐

Left atrium:
- Dimensions: Normal ☐ Abnormal ☐
- LAVI: _______ ml/m²

Right atrium:
- Dimensions: Normal ☐ Abnormal ☐
- RAVI: _______ ml/m²

Apical 2-chamber view:
Normal ☐ Abnormal ☐

Apical 3-chamber view:
Normal ☐ Abnormal ☐

Subcostal view:
Normal ☐ Abnormal ☐

Jugular view:
Dimensions of the aortic arc: Normal ☐ Abnormal ☐
Aortic isthmus stenosis: Yes ☐ No ☐

Summary:
Structural heart disease *(including relevant valve or myocardial disease, coronary anomaly)*:
No ☐ Yes ☐ (please specify: ____)
Normal dimensions:
Yes ☐ No ☐ (specify: ____)
Normal function:
Yes ☐ No ☐ (specify: ____)
Pulmonary hypertension:
No ☐ Yes ☐ (highest systolic RV-/RA-Gradient ________ mmHg)

Further assessment required:
No ☐ Yes ☐ (please specify: ____)

SUMMARISING ASSESSMENT OF ECHOCARDIOGRAPHY ☐ **NORMAL** ☐ **ABNORMAL**

5. BLOOD RESULTS (FASTING)

Haemoglobin Rate (if possible type) _______ mg/dL (   )

Haematocrit _______ %

Erythrocytes _______ mg/dL

Thrombocytes _______ mg/dL

Leukocytes _______ mg/dL

Sodium _______ mmol/L

Potassium _______ mmol/L

Creatinine _______ µmol/L

Cholesterol (total) _______ mmol/L

LDL Cholesterol _______ mmol/L

HDL Cholesterol _______ mmol/L

Triglycerides _______ mmol/L

Glucose _______ mmol/L

C - reactive protein _______ mg/L

If abnormalities arise in any of the examination results relating to the PCMA, we strongly recommend consultation with the respective medical expert. Please also refer to the Associations' Declaration of Agreement to the Pre-Competition Medical Assessment (PCMA). The signed declaration must be returned to the FIFA Medical & Anti-Doping Department before the competition.

6. COVID-19 SPECIFIC TESTS

- In the event of recovery after contamination and known and recognized clinical form of COVID-19: Completely redo the PCMA examination
  - Pulmonary computed tomography (scanner): Search for specific COVID-19 images
  - Cardiac MRI: Look for signs of myocarditis

- Biology: PCR tests MD-14
  - Molecular tests by RT-PCR for the detection of the SARS-CoV-2 coronavirus genome
  - "Virologic Testings" which detect the presence of the SARS-Cov-2 viral genome in the body. NB. Please attach any Imaging and/or Laboratory reports

7. Players' Physical Fitness Certificate (Optional)

- Issued by the Technical Staff of the Team

- Participate in the injury prevention program
  - Iso-kinetic test (Cybex, Contrex or Biodex type)
  - Stress Test (VO2Max)
  - Test - Dental Profile (Occlusion - Odontology)
  - Field tests

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8. SUMMARISING ASSESSMENT

Suspected heart disease

☐ no ☐ yes, please specify: ____

Other diseases

☐ no ☐ yes, please specify: ____

ELIGIBILITY FOR COMPETITIVE FOOTBALL ☐ **yes** ☐ **no**

8. EXAMINING PHYSICIAN AND INSTITUTION

Name of the examining physician:

Address:

Phone No.:

Fax No:

Email

Date:

Signature: