

The Diving Medical Advisory Committee

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Aide Mémoire for Recording and Transmission of Medical Data to Shore

DMAC 01 Rev. 1 – July 2015

Supersedes DMAC 01, which is now withdrawn

C O N F I D E N T I A L

You are not necessarily expected to fill in every page for every patient.

This form has been designed in three parts to make it easier to use.

Part 1 is an aide mémoire to obtain the **initial essential information** for transmission ashore in event of a medical emergency. This information will enable the onshore doctor to advise on immediate management of the casualty.

Part 2 collects more detailed information to provide a permanent record of the incident and to assist in accident analysis. Obviously, in urgent cases **there must be no delay** in contacting medical assistance with the information in Part 1. Part 2 should and can be completed later.

The onshore doctor will frequently ask for some further examination(s) to be carried out.

Part 3 provides a form for recording this information. This part will need to be used initially for the first examination and **may need to be used repetitively at the request of the onshore doctor.**

This part will be a record of your findings at any given time point. There is space to record which time point this is and to be clear regarding date and time and before or after which treatment. This is important in order to be able to get a decent time line on the treatment and progression of each case.

In all parts of this form there are sections which will not be relevant for the type of diving and situation you are in. It is recognised that it will not be necessary to complete the form fully in most cases. **You are not necessarily expected to fill in every page for every patient.**

Where a question (or section) is not applicable, 'N/A' should be entered.

If you are uncertain of the meaning of a question, do not attempt to answer it, but ring the question number, and annotate accordingly.

It is particularly useful to attempt to get photos by whatever means possible, for any unusual occurrence and to forward these on to the Doctors involved in supporting you.

For consistency, please use local time throughout.

This form can also be completed 'electronically'. Instructions for annotating the diagrams can be found at www.dmac-diving.org/guidance/DMAC01-instructions.pdf – **please ensure that you are able to save your file before completing it.**

A check should be made regarding any local data protection legislation as this could impact on the transmission of personal information.

Initial Essential Information for Transmission Ashore In Event of an Emergency

Part I – Section A: General Information

1.	Patient Family name:		First name:	
	Age:		Date of birth (dd/mm/yyyy):	
2.	Company:			
3.	Worksite/vessel:			
4.	Country and/or location:			
5.	Date of onset of incident:		Local time (HH:MM):	
6.	Type of incident: A) Surface supplied <input type="checkbox"/> B) Saturation <input type="checkbox"/> i) Potentially DCI related <input type="checkbox"/> ii) Trauma related <input type="checkbox"/> iii) Other (e.g. possible myocardial infarction) <input type="checkbox"/> ----- ----- -----			
7.	Reason for contacting shore doctor: Assistance required urgently (life threatening) <input type="checkbox"/> Assistance required as soon as possible <input type="checkbox"/> Assistance required when practicable <input type="checkbox"/> Assistance required when patient gets ashore <input type="checkbox"/> For information only <input type="checkbox"/>			
8.	State of consciousness: Fully alert and orientated <input type="checkbox"/> Drowsy (tends to fall asleep) <input type="checkbox"/> Confused <input type="checkbox"/> Unconscious but responds to pain <input type="checkbox"/> Unconscious and unresponsive to pain <input type="checkbox"/>			
9.	Has there been any disease and/or treatment since the last medical certificate for fitness to dive was issued:			Yes <input type="checkbox"/> No <input type="checkbox"/>
10.	Specifically detail any significant past or recent medical history. Please identify any medication taken recently and ask for allergies: ----- ----- ----- -----			

Note: Cumulative hyperbaric exposure is a relevant parameter for assessing the level of individual susceptibility to DCI. Copies of the diver's logbook will show numbers of surface supplied dives – number of days spent in saturation – number of variations in storage depths – number of saturation excursions. A copy of the last medical certificate for fitness to dive and a copy of the last pre-saturation medical examination should be provided.

Part I – Section B: Information about the Dive related to the Incident

(If the illness is not related to diving, skip to Section E)

Patient Family name:		First name:	
Age:		Date of birth (dd/mm/yyyy):	

1. Method:	SCUBA – open circuit <input type="checkbox"/> SCUBA – semi-closed circuit <input type="checkbox"/> SCUBA – closed circuit <input type="checkbox"/> Surface supplied <input type="checkbox"/>	Wet bell <input type="checkbox"/> Bell bounce <input type="checkbox"/> Saturation <input type="checkbox"/>
2. Breathing gas:	Air mixture <input type="checkbox"/> Heliox <input type="checkbox"/>	Nitrox <input type="checkbox"/> Trimix <input type="checkbox"/>
3. Job:	Diver <input type="checkbox"/> Bellman <input type="checkbox"/> Other (specify): <input type="checkbox"/> _____	
4. Working depth:	_____ metres <input type="checkbox"/> /feet <input type="checkbox"/>	
5. Bell depth (where relevant):	_____ metres <input type="checkbox"/> /feet <input type="checkbox"/>	
6. Storage depth (where relevant):	_____ metres <input type="checkbox"/> /feet <input type="checkbox"/>	
7. Time spent at working depth:	_____ minutes	
8. Decompression table and method selected:	In-water <input type="checkbox"/> Nitrox <input type="checkbox"/> If surface decompression, indicate the duration of the surface interval _____ minutes Depth selected: _____ metres <input type="checkbox"/> /feet <input type="checkbox"/> Bottom time selected: _____ minutes Surface interval selected (repetitive dives): _____ hours _____ minutes	
9. Type of work performed during the last working dive:	_____ _____ _____ Workload intensity during the dive (to be assessed by diver and supervisor): Low <input type="checkbox"/> Fair <input type="checkbox"/> High <input type="checkbox"/> Very high <input type="checkbox"/>	
10. Adverse conditions, if any (e.g. sea state, tidal stream, temperature, fouling, disorderly ascent, hard work, etc.):	_____ _____ _____	
11. Did the incident begin:	In the water <input type="checkbox"/> In the bell <input type="checkbox"/> Other (specify): <input type="checkbox"/> _____	In the deck chamber <input type="checkbox"/>
12. At the onset of symptoms, was the patient:	Descending (ambient pressure increasing) <input type="checkbox"/> On the bottom <input type="checkbox"/> Undergoing no pressure change <input type="checkbox"/>	Ascending (ambient pressure decreasing) <input type="checkbox"/> On the surface <input type="checkbox"/> In the DDC <input type="checkbox"/>

Part I – Section C: Compression/Decompression Incident

(If the illness is not related to diving, skip to Section E)

Patient Family name:		First name:	
Age:		Date of birth (dd/mm/yyyy):	

1.	The incident occurred during or immediately following compression:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	The incident occurred during normal decompression:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	The incident occurred after surfacing following normal decompression:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Time of end of decompression at:	_____ hours	_____ minutes
4.	The incident occurred following excursion from saturation:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Was this an upward or downwards excursion:	Up <input type="checkbox"/>	Down <input type="checkbox"/>
	Time of onset after <u>return</u> to storage depth:	_____ hours	_____ minutes
5.	The incident occurred following blow-up/drop in pressure:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	From: _____ Depth: _____ metres <input type="checkbox"/> /feet <input type="checkbox"/>	Local time (HH:MM): _____	
	To: _____ Depth: _____ metres <input type="checkbox"/> /feet <input type="checkbox"/>	Local time (HH:MM): _____	
6.	The incident occurred in other circumstances:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Specify: _____ _____ _____		
7.	How many divers are in the chamber with the affected diver:	_____	
8.	How many of these divers have the DMT qualification:	_____	
9.	Onset of first symptom at:		
	Depth: _____ metres <input type="checkbox"/> /feet <input type="checkbox"/>	Local time (HH:MM): _____	
10.	Niggles (minor aches or itchings, often transient):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11.	Pain in joints:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	State location: _____		
12.	Pain in muscles:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	State location: _____		
13.	Pins and needles (paraesthesia, tingling):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	State location: _____		
14.	Patches of numbness, or altered sensation:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	State location: _____		
15.	Muscle weakness or total loss of power (paralysis):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	State location: _____		
16.	Difficulty in urinating:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17.	Pain in the lumbar region, around waist, or in the abdomen:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Part I – Section C: Compression/Decompression Incident (continued)

(If the illness is not related to diving, skip to Section E)

Patient Family name:		First name:	
Age:		Date of birth (dd/mm/yyyy):	

18. Standing upright is difficult or impossible:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. Nausea:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. Vomiting:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21. Vertigo, loss of balance (dizziness, often with a sense of rotation of either themselves or their surroundings):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. Affected hearing: If yes which side	Both <input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
23. Speech problems:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24. Visual problems (visual acuity, blurred vision, affected field of vision): If yes which side	Both <input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
25. Drowsiness: Specify: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
26. Agitation: Specify: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
27. Breathlessness, painful breathing: Specify: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
28. Respiratory distress worsening with decompression:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
29. Blood-stained froth in or coming from the airways:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
30. Skin: Pruritus (itching) with or without a marbling or erythematous rash:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
31. Sensation of swollen and/or painful skin in any area with or without rash:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
32. Others (please specify any symptoms and their time of appearance and development below): _____ _____ _____ _____ _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

It is particularly useful to attempt to get photos by whatever means possible, for any unusual occurrence and to forward these on to the doctors involved in supporting you.

Part I – Section D: Previous Dive

(If ended less than 24 hours before the accident)

Patient Family name:		First name:	
Age:		Date of birth (dd/mm/yyyy):	

1.	Method:			
	SCUBA – open circuit	<input type="checkbox"/>	Wet bell	<input type="checkbox"/>
	SCUBA – semi-closed circuit	<input type="checkbox"/>	Bell bounce	<input type="checkbox"/>
	SCUBA – closed circuit	<input type="checkbox"/>	Saturation	<input type="checkbox"/>
	Surface supplied	<input type="checkbox"/>		
2.	Breathing gas:			
	Air mixture	<input type="checkbox"/>	Nitrox	<input type="checkbox"/>
	Heliox	<input type="checkbox"/>	Trimix	<input type="checkbox"/>
3.	Depth:		_____ metres <input type="checkbox"/>	_____ feet <input type="checkbox"/>
4.	Bottom time (where relevant):			_____ minutes
5.	Decompression table and method selected:			_____
	In-water	<input type="checkbox"/>	Nitrox	<input type="checkbox"/>
	If surface decompression, indicate the duration of the surface interval			_____ minutes
	Depth selected:			_____ metres <input type="checkbox"/>
	Bottom time selected:			_____ minutes
	Surface interval selected (repetitive dives):		_____ hours	_____ minutes
6.	Normal decompression:		Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	End of decompression:			
	Date (dd/mm/yyyy)		Local time (HH:MM):	
8.	If saturation, when back to storage depth from last working dive:			
	Date (dd/mm/yyyy)		Local time (HH:MM):	
9.	Type of work performed during last working dive:			

10.	Workload intensity during the dive (to be assessed by diver and supervisor):			
	Low <input type="checkbox"/>	Fair <input type="checkbox"/>	High <input type="checkbox"/>	Very high <input type="checkbox"/>
11.	What type of activity does he/she do between dives:			

Part I – Section E: Accident or Illness not related to Decompression

Patient Family name:		First name:	
Age:		Date of birth (dd/mm/yyyy):	

1.	Nature of accident or illness: ----- ----- ----- ----- ----- ----- ----- ----- -----	
2.	Does he/she have difficulty or pain with breathing:	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	Is the diver obviously injured: Describe: ----- ----- ----- ----- -----	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	Is he/she bleeding:	Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	If yes, is bleeding controlled:	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.	State of consciousness: Fully alert and orientated <input type="checkbox"/> Drowsy (tends to fall asleep) <input type="checkbox"/> Confused <input type="checkbox"/> Unconscious but responds to pain <input type="checkbox"/> Unconscious and unresponsive to pain <input type="checkbox"/>	
7.	Details of symptoms: ----- ----- ----- ----- ----- ----- ----- ----- ----- -----	
8.	Treatment given: ----- ----- ----- ----- ----- ----- ----- ----- ----- -----	

Additional Information for Record Purposes

NB. Do **not** delay transmission of Part 1 in order to complete this part of the form

Part 2 – Section A: General Information

(Some of this may be repetitive from Part 1 Section A, but can be completed in greater detail)

1.	Patient Family name:		First name:	
2.	Age:		Date of birth (dd/mm/yyyy):	
	Height (metres):		Weight (kilos):	
	Smoker:			Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	Date of last medical examination (dd/mm/yyyy):			
4.	Where are the medical records held: ----- ----- -----			
5.	Details of main medical carer, including address (be it a GP or other): ----- ----- ----- E-mail address: ----- Phone number: -----			
6.	Details of any previous or possible decompression sickness: ----- ----- -----			
7.	Has there been any disease and/or treatment since the last medical certificate for fitness to dive was issued:			Yes <input type="checkbox"/> No <input type="checkbox"/>
8.	Specifically detail any significant past or recent medical history. Please identify any medication taken recently and ask for allergies: ----- ----- -----			
9.	Have there been any specific activities or travel during the previous two months:			Yes <input type="checkbox"/> No <input type="checkbox"/>
10.	Name of diving supervisor: ----- E-mail address: ----- Phone number: -----			
11.	Name of medical attendant: ----- E-mail address: ----- Phone number: -----			
12.	Local time (HH:MM) of transmission of Part 1:		Date (dd/mm/yyyy):	
13.	Addressee: -----			
14.	Copied to: -----			

Part 3 – Section B: Cardiorespiratory Systems

Family name:		First name:		Date of birth:	
Exam number:		Time:		Date:	
Country and/or location:					

1.	Is his/her colour (look at lips and nail beds):	Normal <input type="checkbox"/>	Pale <input type="checkbox"/>	Cyanosed (blue) <input type="checkbox"/>
2.	Is he/she visibly sweating:	Yes <input type="checkbox"/>		No <input type="checkbox"/>
3.	What is his/her:			
	i) Pulse (count for 30 seconds, then x 2)	_____ per min		
	Is the pulse regular:	Yes <input type="checkbox"/>		No <input type="checkbox"/>
	ii) Blood pressure	_____ Syst	_____ Diast	
	iii) Respiratory rate (count for 30 seconds, then x 2)	_____ per min		
4.	iv) Pulse oximetry	_____ %		
	v) Measure the capillary refill time (use your thumb to press down the nail on the patient's index finger for 5-10 seconds. Release the pressure – how long does it take to get normal nail bed colour back?)	_____ seconds		
4.	Does he/she have pain or difficulty breathing:	Yes <input type="checkbox"/>		No <input type="checkbox"/>
	If 'yes', describe:	_____ _____ _____		
5.	Does he/she have a cough:	Yes <input type="checkbox"/>		No <input type="checkbox"/>
	If 'yes', has he/she coughed blood:	Yes <input type="checkbox"/>		No <input type="checkbox"/>
6.	Is he/she short of breath:	Yes <input type="checkbox"/>		No <input type="checkbox"/>
	If 'yes', has this been affected by:			
	i) increase of pressure	Yes <input type="checkbox"/>		No <input type="checkbox"/>
	ii) decrease of pressure	Yes <input type="checkbox"/>		No <input type="checkbox"/>
7.	Is the trachea (windpipe) central (i.e. normal):	Yes <input type="checkbox"/>		No <input type="checkbox"/>
8.	Are breath sounds audible equally on both sides of the chest (listen at three different levels – preferably over the back):	Yes <input type="checkbox"/>		No <input type="checkbox"/>
9.	Is there any subcutaneous emphysema (crackling sensation in the tissues around the thorax) (carefully feel in each triangular area between the shoulder and the neck)	Yes <input type="checkbox"/>		No <input type="checkbox"/>

Part 3 – Section C: Abdomen

Family name:		First name:		Date of birth:	
Exam number:		Time:		Date:	
Country and/or location:					

1.	<p>Does the patient have abdominal pain:</p> <p>If 'yes', specify site by writing on the chart, and make a note of the character:</p> <div style="text-align: center;"> </div>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
When examining points 2-4, gently touch (palpate) the abdomen in each of the four quadrants			
2.	<p>Does it feel soft:</p> <p>If 'no', specify the site (by writing 2 on the chart above, over the appropriate area)</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	<p>Are there any swellings:</p> <p>If 'yes', specify site (by writing 3 on the chart above, over the appropriate area), size and consistency:</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	<p>Is the abdomen tender:</p> <p>If 'yes', specify the site (by writing 4 on the chart above, over the appropriate area; assess tenderness by slowly depressing and then abruptly removing pressure in each quadrant)</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	<p>Can you hear bowel sounds with a stethoscope used for one minute:</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	<p>Does the patient have diarrhoea:</p> <p>If 'yes', specify:</p> <p>a) When the patient last opened his/her bowels</p> <p>b) Specify the frequency in the last 24 hours</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	<p>Has the patient vomited:</p> <p>If 'yes', specify:</p> <p>a) When the patient last vomited</p> <p>b) If he/she is still vomiting, specify frequency and character:</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Part 3 – Section C: Abdomen (continued)

Family name:		First name:		Date of birth:	
Exam number:		Time:		Date:	
Country and/or location:					

8.	Has he/she vomited blood:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
9.	Can the patient pass urine without difficulty:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	When did the patient last pass urine			
10.	Is urinating painful:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
11.	Is the urine			
	Clear <input type="checkbox"/>	Blood-stained (red) <input type="checkbox"/>		
	Other (explain) <input type="checkbox"/>	-----		
12.	Urine colour (tick applicable reference colour):			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Urine dip stick results (when reading results from the side of a bottle check order of results – they are usually, but not always, in order given below):			
	Leukocytes	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Nitrite	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Urobilinogen	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Protein	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	pH	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Haemoglobin	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Specific gravity	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Ketone	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Bilirubin	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Glucose	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Record in more detail any positive results (semi-quantitative values are usually reported as: trace, 1+, 2+, 3+ and 4+):			

14.	Additional comments			

Part 3 – Section D: Nervous System

(This may be the most frequently repeated of the examinations, and this section may need to be used and transmitted several times)

Patient Family name:		First name:	
Age:		Date of birth (dd/mm/yyyy):	
Country and/or location:			

Time point (please complete date (dd/mm/yyyy) and local time (HH:MM)):		
Initial examination:	Date	Time
Pre- or post-therapy:	Pre <input type="checkbox"/>	Post <input type="checkbox"/>
This examination:	Date	Time
Therapy number:		
Examination number:		
Name of person examining:		

1.	Has he/she had any visual disturbance:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'yes', specify: _____ _____		
2.	Has he/she had a headache:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'yes', specify the location and timing of this headache: _____		
	Headache pain intensity score. Visual analogue scale (0 being no pain, 10 being the worst pain imaginable)		
	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
	9 <input type="checkbox"/>	10 <input type="checkbox"/>	
3.	State of consciousness: Fully alert and orientated <input type="checkbox"/> Drowsy (tends to fall asleep) <input type="checkbox"/> Confused <input type="checkbox"/> Unconscious but responds to pain <input type="checkbox"/> Unconscious and unresponsive to pain <input type="checkbox"/>		
4.	Are his/her pupils equal and reactive to light:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Quickly point a flashlight beam into the right pupil. Does it contract? Repeat the test. Does the opposite pupil contract similarly? Repeat examination on the left eye in a similar fashion. If 'no', specify: _____ _____ _____		
5.	Does the patient have vertigo (dizziness, often with a sense of rotation of either themselves or their surroundings):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Does the patient have normal vision:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Put your index finger approx. arm's length in front of the patient's nose. Ask the patient to focus on it.		
	Can he/she see it sharply:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Does he/she have double vision:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Part 3 – Section D: Nervous System (continued)

Family name:		First name:		Date of birth:	
Exam number:		Time:		Date:	
Country and/or location:					

7.	<p>Does the patient have nystagmus (eye flickering):</p> <p>Put your index finger approx. arm's length in front of the patient's nose. Ask the patient to focus on it. Slowly move your finger in an 'H' pattern. Is there any nystagmus (uncontrolled oscillatory or jerky eye movements)? Particularly look for this when the patient is gazing almost at the extreme of eye movement. You may be able to get a video of this movement and send it to the onshore doctor.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>																																																
8.	<p>Is hearing equal and normal in both ears:</p> <p>Stand behind the patient or ask him to close his/her eyes. Slide/rub your fingers against each other outside his/her right ear. Ask him to tell you when he/she can hear it. Repeat the examination on the left ear. Is there any difference? Alternatively: Put the patient 2-3 m in front of you with his/her back against you. Ask him to cover his/her right ear. Whisper two-digit numbers (21-99) and ask him to repeat it. Redo with left ear. Is there any difference between the two sides? In a normal diving environment this is likely to be difficult – we are only looking for obvious problems.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>																																																
9.	<p>Are the remainder of the cranial nerves normal:</p> <p>Are both eye movements equal and normal: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is facial sensation normal (test on three levels on each side): Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are facial movements normal on both sides (smile, close and open both eyes shrug his/her upper face and blow out cheeks): Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Can he/she swallow easily (look for movement of the larynx): Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the soft palate symmetrically positioned in the throat without deviation of the uvula: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Can he/she shrug his/her shoulders equally (with and without resistance): Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are his/her tongue movements normal (does the tongue deviate when stretched straight forwards and can it move normally?): Yes <input type="checkbox"/> No <input type="checkbox"/></p>																																																		
10.	<p>Can the patient voluntarily move his:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">R Shoulder</td> <td style="width: 10%;">Yes <input type="checkbox"/></td> <td style="width: 10%;">No <input type="checkbox"/></td> <td style="width: 25%; border-left: 1px solid black;">L Shoulder</td> <td style="width: 10%;">Yes <input type="checkbox"/></td> <td style="width: 10%;">No <input type="checkbox"/></td> </tr> <tr> <td>R Elbow</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td style="border-left: 1px solid black;">L Elbow</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>R Wrist</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td style="border-left: 1px solid black;">L Wrist</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>R Fingers</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td style="border-left: 1px solid black;">L Fingers</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>R Hip</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td style="border-left: 1px solid black;">L Hip</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>R Knee</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td style="border-left: 1px solid black;">L Knee</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>R Ankle</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td style="border-left: 1px solid black;">L Ankle</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>R Toes</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td style="border-left: 1px solid black;">L Toes</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	R Shoulder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L Shoulder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	R Elbow	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L Elbow	Yes <input type="checkbox"/>	No <input type="checkbox"/>	R Wrist	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L Wrist	Yes <input type="checkbox"/>	No <input type="checkbox"/>	R Fingers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L Fingers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	R Hip	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L Hip	Yes <input type="checkbox"/>	No <input type="checkbox"/>	R Knee	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L Knee	Yes <input type="checkbox"/>	No <input type="checkbox"/>	R Ankle	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L Ankle	Yes <input type="checkbox"/>	No <input type="checkbox"/>	R Toes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L Toes	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
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11.	<p>Has he/she any weakness:</p> <p>Examine the force that is achievable in each joint listed above. Wherever possible ask him to contract muscles on both sides against your resistance. Carefully consider: Is the force equal on the two sides? Is the force considered normal by yourself and the patient? Most joints (e.g. wrist, elbow, knee and ankle) have only two directions of movement (one plane) but the hip and shoulder should be assessed for movements in two planes. It is common to be slightly stronger on the dominant (usually right) side.</p> <p>If 'yes', specify:</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>																																																

Part 3 – Section D: Nervous System (continued)

Family name:		First name:		Date of birth:	
Exam number:		Time:		Date:	
Country and/or location:					

12.	Are reflexes (tendon jerks):		Normal	Increased	Absent	Not clear
	Triceps	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Biceps	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Knee	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ankle	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The reflex examination is only to be completed by trained persons and should not delay other examinations. When assessing reflexes note carefully any difference between the two sides (this is more important than the strength of the reflexes).</p>						
13.	Is the plantar response:				↑R <input type="checkbox"/>	↑L <input type="checkbox"/>
				OR	↓R <input type="checkbox"/>	↓L <input type="checkbox"/>
				or not clear	R <input type="checkbox"/>	L <input type="checkbox"/>
<p>The plantar response is tested by drawing a moderately sharp, but non-injuring object (e.g. the tip of a pen) on outermost part of the sole of the foot from the heel to the fifth toe. Carefully observe the first direction of movement of the first (great) toe.</p>						
14.	Does he/she feel any altered feelings in the skin (numbness, pins and needles):				Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'yes', specify and identify on the diagram on page 19 _____					
15a.	Is there a normal sensory response to soft touch:				Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'no', specify and identify on the diagram on page 19 _____					
<p>Use a cotton wool or textile to lightly touch the back of his/her right big toe. Repeat on the left side. Is there normal sensation? Is this equal on the two sides? Repeat successively on representative parts of the rest of the body ensuring you touch both outer and inner parts of the legs and arms. It is not necessary to examine skin sensation on the back if you compare right and left side on 5-6 levels on abdomen and thorax</p>						
15b.	Is there a normal sensory response to pinprick:				Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'no', specify and identify on the diagram on page 19 _____					
<p>Use a toothpick or a similar sharp (but not wounding) object to test for sensation of sharpness. Otherwise do the test as per 15</p>						
16.	Can you detect a level of sensory change:				Yes <input type="checkbox"/>	No <input type="checkbox"/>
17.	Does he/she have distal vibration sensation (using 128Hz tuning fork):				Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'no', specify: _____					
<p>Ask him to close his/her eyes. Put the 128Hz tuning fork on the top of the joint of the big toe. It should explained to the patient that it is the sensation of vibration, not cold or touch, which is being tested. The test may be made more objective and sensitive by giving a careful explanation and demonstration of the vibratory sensation. Place the tuning fork on the joint of the big toe, sometimes vibrating and sometimes not. If he/she has absent vibration sensation on the big toe, perform this test again on the lateral malleolus (ankle bone).</p>						

Part 3 – Section D: Nervous System (continued)

Family name:		First name:		Date of birth:	
Exam number:		Time:		Date:	
Country and/or location:					

18.	Does he/she have equal and seemingly normal proprioceptive (joint position) sense:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'no', specify:		

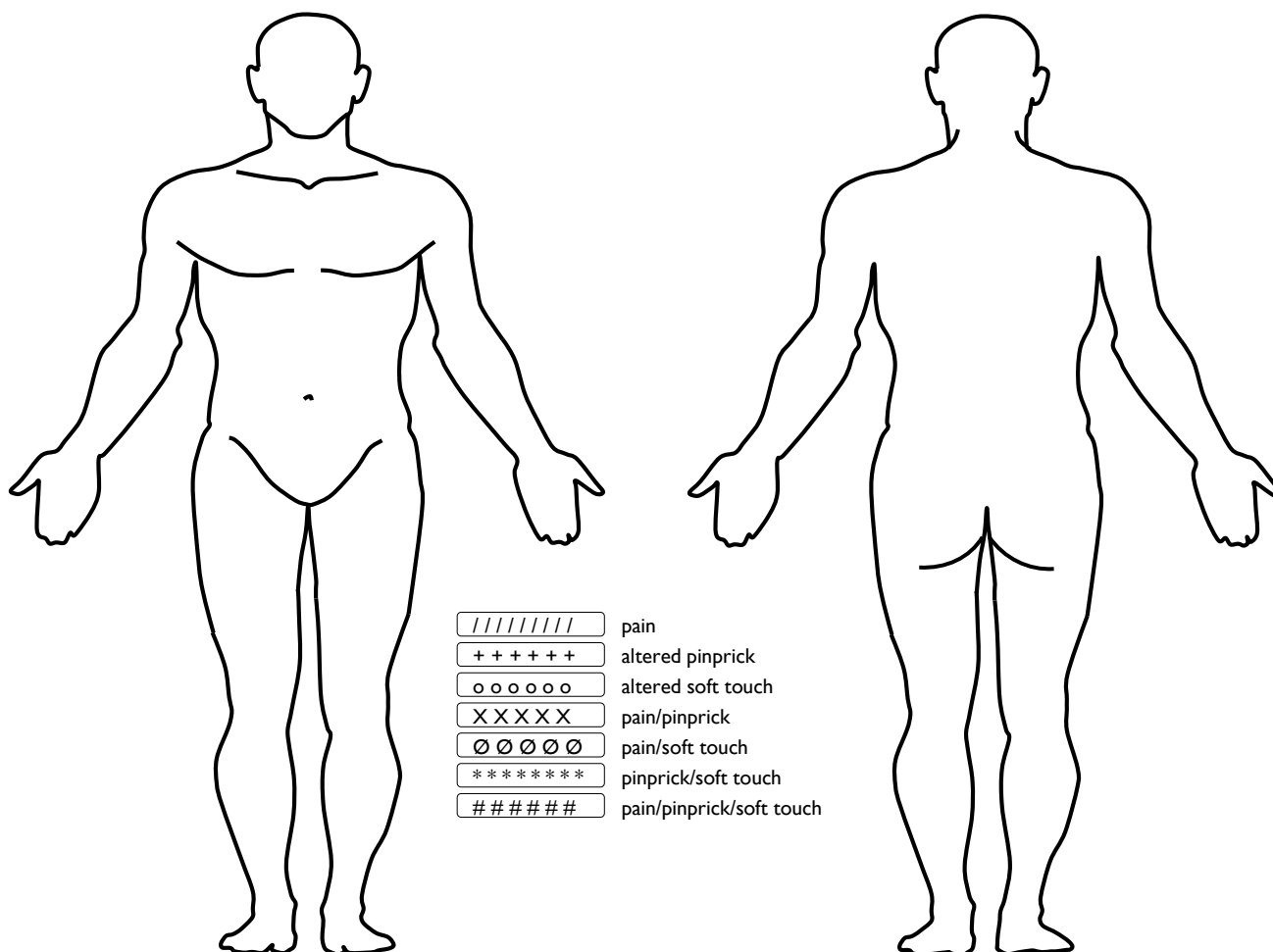
	<p>Grasp his/her right big toe with one finger on each side (not on sole/back). Ask him to close his/her eyes and keep them closed for this test. Put the toe in the maximum upper position and explain 'This is up'. Then move the toe to the maximum downward position and explain 'This is down'.</p> <p>Then position the toe in the mid/neutral position and ask him to notify the direction of the movement when you slowly move the toe upwards. Repeat the movement in different directions (a few times) to learn his/her threshold for joint movement.</p> <p>Repeat the examination on the left side.</p> <p>Ensure you move the toe more than 10 degrees in arc, with larger movements first, then smaller ones.</p>		

Please document your findings on the diagrams below.

Mark areas of altered sensation as shown below. Please note these may change over time with treatment.

Also use this diagram to show any other findings of interest.

If there are visible signs – please remember that photos are very useful.



Part 3 – Section D: Nervous System (continued)

Family name:		First name:		Date of birth:	
Exam number:		Time:		Date:	
Country and/or location:					

19.	Does he/she have a normal finger–nose test:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>This is a useful test of co-ordination in the arms. Stand in front of him and ask him to touch the tip of your index finger held in front of his/her nose, with the index finger of his/her outstretched right arm and then to touch the tip of his/her nose.</p> <p>He should be able to do this repeatedly, both with his/her eyes open and closed.</p> <p>You needed to assess smoothness of movement and accuracy.</p> <p>Repeat the test using his/her left arm.</p> <p>The sensitivity of this test can be increased by the examiner moving his/her finger to a different place whilst the patient's finger is en route to it with his/her eyes open.</p>			
20.	Does he/she have a normal heel–shin test:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>This is a useful test of co-ordination in the legs. When he/she is lying flat ask him to place the heel of his/her right foot on the opposite knee and then slide it down accurately, on the shin, to the ankle and back.</p> <p>He should be able to do this with his/her eyes open and closed.</p> <p>You needed to assess smoothness of movement and accuracy.</p> <p>Repeat the test using his/her left foot.</p>			
21.	Can he/she perform a normal tandem gait walk (heel–toe walking):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>Ask him to walk heel to toe for about 10 steps both forwards and backwards with his/her eyes open first and then with his/her eyes closed.</p> <p>Be prepared to catch him in case he/she falls.</p>			
22.	Is the Romberg test positive or negative	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>
<p>Ask him to remove his/her shoes and stand with his/her two feet together. his/her arms should be held by his/her sides.</p> <p>You should ask him to first stand quietly with eyes open, and then with his/her eyes closed. he/she should try to maintain his/her balance.</p> <p>Be prepared to catch him in case he/she falls.</p> <p>This test is scored by counting the seconds he/she is able to stand with eyes closed.</p> <p>Record seconds he/she is able to stand with eyes closed.</p> <p>Romberg's test is positive if he/she sways significantly or falls while his/her eyes are closed.</p> <p>This test may not be possible to use on a vessel in motion – it should only be performed on a stable and solid 'platform'.</p>			
23.	Is the Sharpened Romberg test positive or negative	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>
<p>Test results in seconds: 1st _____ 2nd _____ 3rd _____ 4th _____</p> <p>Ask him to remove his/her shoes and stand with his/her feet in a tandem gait (heel–toe) position. his/her arms should be crossed over the chest.</p> <p>You should ask him to first stand quietly with eyes open, and then with his/her eyes closed. he/she should try to maintain his/her balance.</p> <p>Be prepared to catch him in case he/she falls.</p> <p>This test is scored by counting the seconds he/she is able to stand with eyes closed. The test should be conducted up to four times for up to a minute.</p> <p>This Sharpened Romberg's test is positive if he/she sways or falls while his/her eyes are closed.</p> <p>This test may not be possible to use on a vessel in motion – it should only be performed on a stable and solid 'platform'.</p>			

