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Case Number / Hospital Number

Neurological Assessment for Multiple Sclerosis and Extended Disability Scale Score

This section **should only** be completed by a neurologist or MD / ROD (Medical Doctor / Resident on Duty) involved in the care of the person. **If you are not the person's neurologist or physician please leave this section blank.** If you are the person's neurologist or physician please complete this section on **each** person notified.

Full Name of person completing this form (Your name):
(Complete in full for the **first patient you notify** to us thereafter we only require your **name**, or stamp **and the date**.)

_____

Date Form Completed: _____

Address: _____

_____

Phone Number : _____
(Area Code) Number

E-mail Address: _____

Designation: _____

Neurological Assessment

1. Year of MS Diagnosis

☐☐

_____

2. Year of onset of 1st symptoms

☐☐

_____

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3. **Nature of 1st symptoms (***(please tick **one** box only)*

- ☐ Optic neuritis
- ☐ Spinal cord
- ☐ Brainstem/cerebellar
- ☐ Sensory only
- ☐ Polysymptomatic
- ☐ Other please state _____

4. **Type of MS** *(please tick **one** box only)*

- ☐ Single demyelinating event
- ☐ Relapsing/Remitting
- ☐ Secondary Progressive
- ☐ Progressive since onset
- ☐ Not MS

5. **How has the diagnosis been confirmed at any stage?** Please include **all** events and tests performed up to and including March 6th 2006 *(please tick the appropriate **box** or **boxes**)*

a) Relapses
(Symptoms lasting more than 24 hrs)

☐ 2 or more attacks. (Greater than 30 days apart)

Or ☐ Single attack

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b) Progressive Neurological Signs
(include both primary or secondary progression

☐ Greater than or equal to 12 months

Or

☐ Less than 12 months ☐

c) Clinical signs

☐ Single clinical lesion

Or

☐ 2 or more separate clinical lesions ☐

d) **Oligoclonal Bands**

Not done	Positive	Negative	
☐	☐	☐	☐

e) **Visual Evoked Potentials**

Not done	Abnormal	Normal	
☐	☐	☐	☐

f) **MRI**

	Not Done	Consistent with demyelination single lesion	Consistent with demyelination 2 or more lesions	Normal	
Brain	☐	☐	☐	☐	☐
Spinal Cord	☐	☐	☐	☐	☐

6. **Has the patient been assessed in the last 12 months?**

☐ Yes**.** Please go to Question 7.

☐ No. **No more questions thank you.**

☐

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7. At the time of the last assessment which of the following **best** fits the patient's level of disability. **(**Please **do not** include assessments done at the time of a relapse. If only assessed at the time of a relapse please leave this question blank**).**

Date of neurological assessment _____

- ☐ 0. Normal findings on neurological examination
- ☐ 1. No disability. Minimal signs on neurological examination.
- ☐ 2. Minimal and non ambulation-related disability. Able to run.
- ☐ 3. Unlimited walking distance without rest, but unable to run; or a significant non ambulation-related disability.
- ☐ 4. Walk without aid. Limited walking distance but **greater than or equal to** 500 metres without rest.
- ☐ 5 Walks without aid. Walking distance **less than** 500 metres
- ☐ 6A. Walks with permanent **unilateral** supported **less than** 100 metres without resting.
- ☐ 6B. Walks with permanent **bilateral** support **less than** 100 metres without resting.
- ☐ 7. Home restricted. A few steps with wall or furniture assistance. Walking distance **less than** 20 metres.
- ☐ 8. Chair restricted. Unable to take a step. Some effective use of upper limbs.
- ☐ 9. Bedridden and totally helpless.
- ☐ 10. Death due to MS

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8. If completed in the last 12 months please indicate the patients Extended Disability Scale Score. (See attached sheet).
(Please **do not** include assessments done at the time of a relapse. If only assessed at the time of a relapse please leave this question blank).

Date of latest EDSS assessment _____

EDSS ☐.☐

Thank you for completing this form