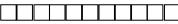


Neurological Assessment for Multiple Sclerosis and Extended Disability Scale Score

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.

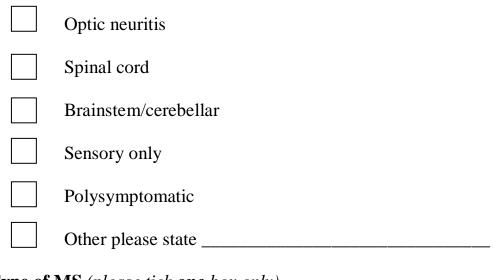
Full Name of person completing this form (Your name): (Complete in full for the **first patient you notify** to us thereafter we only require your **name**, or stamp **and the date**.)

Date Form Completed:	
Address:	
Phone Number :	
Phone Number :(Area Code) Number	
E-mail Address:	
Designation:	
Neurological Assessment	
1. Year of MS Diagnosis	
2. Year of onset of 1 st symptoms	



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Case Number / Hospital Number
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3. Nature of 1st symptoms ((*please tick one box only*)



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*)

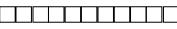
a) Relapses		2 or more attacks.
(Symptoms lasting		(Greater than 30 days apart)
more than 24 hrs)		
	Or	Single attack

b) Progressive

Neurological Signs

Case Number / Hospital Number Greater than or equal to 12 months	

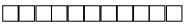
(include both primary secondary progress)		than 12 months		
c) Clinical signs	Singl	e clinical lesion		
	Or 2 or 1	more separate clinic	cal lesions	
d) Oligoclonal Bands	Not done	Positive		
e) Visual Evoked Potentials	Not done	Abnormal	Normal	
f) MRI Not Done	Consistent with demyelination single lesion	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	e questions thank y	7 0u.	



Case Number / Hospital Number

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		Case Number / Hospital Number			
the patient'	s leve relaps	f the last assessment which of the following best fits el of disability. (Please do not include assessments done at se. If only assessed at the time of a relapse please leave this			
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			



Case Number / Hospital Number

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

Thank you for completing this form