

# IFSC Relative Energy Deficiency in Sport (REDS) Health Certification



Please read and consent to the details below:

I (Athlete) \_\_\_\_\_

Hereby consent to the BMC storing the medical information shared in this form in accordance with the following purposes.

- In accordance with the [BMC Athlete Health Policy](#).
- In accordance with the requirements of the IFSC National Federation Responsibilities in the [IFSC Relative Energy deficiency in Sport \(REDS\)](#) for athletes ages 15 years and older.

Hereby consent to the BMC sharing the medical information shared in this form in accordance with the following purpose,

- If through the completion of these medical forms a health concern is raised the BMC athlete health lead will be informed so that the athlete referral pathways can be followed in accordance with the BMC Athlete Health Policy.

The information provided as per this form will ensure this personal information collected is safe and secure and will be stored as per the [BMC Privacy Policy](#) and **WILL NOT** be shared with the IFSC directly.

(This is due to the IFSC not yet being able to supply data processing contracts as per GDPR legal requirements in the UK)

**It is the athlete's responsibility to upload the information on this form to the IFSC portal in support of the IFSC International Competition license application made by the BMC as the recognised National Federation of Sport Climbing in the UK.**

If an athlete's details and/or contact details change it is their personal responsibility to inform the BMC so that records can be updated.

## Withdrawal of consent

Your consent can be revoked at any time by contacting the DPO at the BMC at [office@thebmc.co.uk](mailto:office@thebmc.co.uk). At which time the information will be deleted as per your request.

Signed (athlete) \_\_\_\_\_ Print name \_\_\_\_\_ Date \_\_\_\_\_

Signed (parent) \_\_\_\_\_ Print name \_\_\_\_\_ Date \_\_\_\_\_

**Please return this completed form to [gbcadmin@thebmc.co.uk](mailto:gbcadmin@thebmc.co.uk)**

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This form is to be completed and signed by a medical practitioner and returned to [gbcadmin@thebmc.co.uk](mailto:gbcadmin@thebmc.co.uk)

|               |  |
|---------------|--|
| Name          |  |
| Date of Birth |  |
| Address       |  |

Questionnaire results (only for athletes aged 15 years and over):

| TYPE      | Score (or n/a) | Cut off | Any action required |
|-----------|----------------|---------|---------------------|
| LEAM-Q SV |                | ≥2      |                     |
| LEAF-Q    |                | ≥8      |                     |
| EDE-Q SV  |                | >15     |                     |

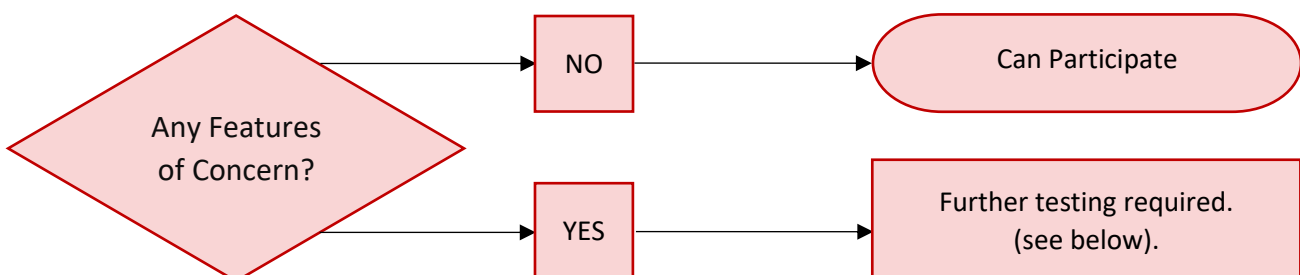
Examination:

|                     |  |
|---------------------|--|
| Height              |  |
| Weight              |  |
| BMI                 |  |
| Any action required |  |

|                               |  |
|-------------------------------|--|
| Heart rate seated at rest     |  |
| Blood pressure seated at rest |  |
| Any action required           |  |

Features of Concern:

- REDs Questionnaire scores: athlete's score is equal to or higher than the cut-off value on one or both questionnaires.
- BMI: Males 18 years old and older < 18.5; Males 15 – 17 years old: < 18 Females 18 years old and older < 18, Females 15 – 17 years old: < 17.5.
- Heart Rate: 18 years and older < 50bpm
- Blood Pressure: < 90/60 mm HgC



Further testing in all athletes of concern, arrange specialist referral for medical, mental health and nutritional assessment and undertake further medical and laboratory evaluation:

1. Bone Mineral Density /DXA (dual energy X-ray absorptiometry)
2. Total and Free Testosterone
3. Thyroid Function Test including Free T3
4. Full fasting lipid profile
5. Review growth chart if athlete is <18 years of age

For further details please see [here](#)

# IFSC Relative Energy Deficiency in Sport (REDS) Health Certification



Please indicate appropriate action:

|  |
|--|
| <b>Athlete is clear to participate.</b>                        |
| <b>OR</b>  |
| <b>Athlete requires investigation through further testing.</b> |

|                      |  |
|----------------------|--|
| Any further comments |  |
|----------------------|--|

|                               |  |
|-------------------------------|--|
| Name of Medical Practitioner: |  |
| Qualifications                |  |
| Medical Speciality            |  |
| GMC Number                    |  |
| Date of assessment            |  |

Signed:

|                 |
|-----------------|
| Practice Stamp: |
|-----------------|