Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
AMPUTATIONS DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim. VA reserves the right to confirm the authenticity of ALL DBQ's completed by private health care providers.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

☐ YES ☐ NO

How was the examination completed? (check all that apply)

- ☐ In-person examination
- ☐ Records reviewed
- ☐ Examination via approved video telehealth
- ☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

- ☐ Not requested
- ☐ VA claims file (hard copy paper C-file
- ☐ VA e-folder (VBMS or Virtual VA)
- ☐ CPRS
- ☐ Other (please identify other evidence reviewed):
- ☐ No records were reviewed

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

1A. HAS THE VETERAN HAD ANY AMPUTATIONS?

☐ YES ☐ NO

1B. IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO AMPUTATION(S)

AMPUTATION # 1 -	ICD CODE -	DATE OF AMPUTATION -
AMPUTATION # 2 -	ICD CODE -	DATE OF AMPUTATION -
AMPUTATION # 3 -	ICD CODE -	DATE OF AMPUTATION -

1C. IF ADDITIONAL AMPUTATION(S) EXIST, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ETIOLOGY AND COURSE) OF EACH AMPUTATION LISTED ABOVE:

2B. DOMINANT HAND

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION III - AMPUTATION(S) SITE(S)

4. AMPUTATION(S) SITE(S) *(Indicate affected sites):*

☐ UPPER EXTREMITIES *(not including the fingers)*

☐ FINGERS

☐ LOWER EXTREMITIES *(not including the toes)*

☐ TOES

For all checked sites, complete the corresponding sections below.

SECTION IV - UPPER EXTREMITIES (NOT INCLUDING FINGERS)

4A. DOES THE VETERAN HAVE AN AMPUTATION OF EITHER ARM?

☐ YES ☐ NO *(If "Yes," indicate site and side affected (check all that apply))*

☐ Amputation is below insertion of deltoid ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

☐ Amputation is above insertion of deltoid ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

☐ Disarticulation ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

4B. DOES THE AMPUTATION SITE ALLOW THE USE OF A SUITABLE PROSTHETIC APPLIANCE?

☐ YES ☐ NO *(If "Yes," indicate site and side affected (check all that apply))*

☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

4C. IS THERE AN AMPUTATION OF EITHER FOREARM?

☐ YES ☐ NO *(If "Yes," indicate site and side affected (check all that apply))*

☐ Amputation below insertion of pronator teres ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

☐ Amputation above insertion of pronator teres ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

☐ Amputation resulting in loss of use of the hand ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

SECTION V - FINGERS

5A. DOES THE VETERAN HAVE AN AMPUTATION OF EITHER THUMB?

☐ YES ☐ NO *(If "Yes," indicate site and side affected (check all that apply))*

☐ Amputation at the distal joint or through the distal phalanx	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**
☐ Amputation at the metacarpophalangeal joint or through the proximal phalanx	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**
☐ Amputation with metacarpal resection	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**

5B. DOES THE VETERAN HAVE AN AMPUTATION OF ANY FINGERS?

☐ YES ☐ NO *(If "Yes," indicate site and side affected (check all that apply))*

☐ **LEFT**

☐ Amputation through the long phalanx or at the distal joint

☐ Right index finger	☐ Right long finger	☐ Right ring finger	☐ Right little finger
☐ Left index finger	☐ Left long finger	☐ Left ring finger	☐ Left little finger
☐ Both index fingers	☐ Both long fingers	☐ Both ring fingers	☐ Both little fingers

☐ Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto

☐ Right index finger	☐ Right long finger	☐ Right ring finger	☐ Right little finger
☐ Left index finger	☐ Left long finger	☐ Left ring finger	☐ Left little finger
☐ Both index fingers	☐ Both long fingers	☐ Both ring fingers	☐ Both little fingers

☐ Amputation with metacarpal resection (more than one-half the bone lost)

☐ Right index finger	☐ Right long finger	☐ Right ring finger	☐ Right little finger
☐ Left index finger	☐ Left long finger	☐ Left ring finger	☐ Left little finger
☐ Both index fingers	☐ Both long fingers	☐ Both ring fingers	☐ Both little fingers

SECTION VI - LOWER EXTREMITIES (NOT INCLUDING THE TOES)

6A. DOES THE VETERAN HAVE AN ABOVE-KNEE AMPUTATION OF THE THIGH?

☐ YES ☐ NO *(If "Yes," indicate site and side affected (check all that apply))*

☐ Amputation of the middle or lower third	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**
☐ Amputation of the upper third, one-third of the distance from the perineum to the knee joint, measured from the perineum	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**
☐ Disarticulation with loss of extrinsic pelvic girdle muscles	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**

6B. DOES THE THIGH AMPUTATION SITE ALLOW THE USE OF A SUITABLE PROSTHETIC APPLIANCE?

☐ YES ☐ NO

If "Yes," indicate side that allows use of suitable prosthetic appliance: ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

6C. DOES THE VETERAN HAVE A BELOW-KNEE AMPUTATION OF THE LOWER LEG, INCLUDING FOREFOOT?

☐ YES ☐ NO *(If "Yes," indicate site and side affected (check all that apply))*

☐ **LEFT**

☐ Amputation of the forefoot, which is proximal to the metatarsal bones (more than one-half of metatarsal loss)	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**
☐ Amputation between the forefoot and knee, permitting prosthesis	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**
☐ Amputation not improvable by prosthesis controlled by natural knee action	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**
☐ Amputation with defective stump and amputation of the thigh recommended	☐ **LEFT**	☐ **RIGHT**	☐ **BOTH**

6D. DOES THE LOWER LEG AMPUTATION SITE ALLOW THE USE OF A SUITABLE PROSTHETIC APPLIANCE?

☐ YES ☐ NO

If "Yes," indicate side that allows use of suitable prosthetic appliance: ☐ **LEFT** ☐ **RIGHT** ☐ **BOTH**

SECTION VII - TOES

7A. DOES THE VETERAN HAVE AN AMPUTATION OF ANY TOES?

☐ YES ☐ NO *(If "Yes," indicate site and side affected (check all that apply))*

☐ Amputation of toes without removal of the metatarsal head?

(If checked, indicate site and side affected (check all that apply)

☐ Right great toe	☐ Right 2nd toe	☐ Right 3rd toe	☐ Right 4th toe	☐ Right little toe
☐ Left great toe	☐ Left 2nd toe	☐ Left 3rd toe	☐ Left 4th toe	☐ Left little toe
☐ Both great toe	☐ Both 2nd toe	☐ Both 3rd toe	☐ Both 4th toe	☐ Both little toe

☐ Amputation of toes with removal of the metatarsal head?

(If checked, indicate site and side affected (check all that apply)

☐ Right great toe	☐ Right 2nd toe	☐ Right 3rd toe	☐ Right 4th toe	☐ Right little toe
☐ Left great toe	☐ Left 2nd toe	☐ Left 3rd toe	☐ Left 4th toe	☐ Left little toe
☐ Both great toe	☐ Both 2nd toe	☐ Both 3rd toe	☐ Both 4th toe	☐ Both little toe

SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

8A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, DESCRIBE *(brief summary):*

8B. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF "YES," ARE ANY OF THESE SCARS PAINFUL AND/OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM 6 square inches); OR ARE LOCATED ON THE HEAD, FACE, OR NECK? *(An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)*

☐ YES ☐ NO

IF "YES," ALSO COMPLETE VA FORM 21-0960F-1, *SCARS/DISFIGUREMENT*.

IF "NO," PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION:_____ MEASUREMENTS: Length _____ cm X width _____ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in the Comments Section below. It is not necessary to also complete a Scars DBQ.

5C. COMMENTS, IF ANY:

SECTION IX - ASSISTIVE DEVICES

9A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

☐ YES ☐ NO *(If "Yes," identify assistive devices used - check all that apply and indicate frequency)*

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

9B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION X - DIAGNOSTIC TESTING

NOTE - Imaging studies are not required to document amputations.

10. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO *(If "Yes," provide type of test or procedure, date and results - brief summary):*

SECTION XI - FUNCTIONAL IMPACT

11. DO ANY OF THE VETERAN'S AMPUTATIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the Veteran's amputations providing one or more examples):*

SECTION XIII - REMARKS

13. REMARKS *(If any):*

SECTION XIV - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

14A. PHYSICIAN'S SIGNATURE	14B. PHYSICIAN'S PRINTED NAME	14C. DATE SIGNED

14D. PHYSICIAN'S PHONE NUMBER	14E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	14F. PHYSICIAN'S ADDRESS

NOTE: VA may obtain additional medical information, including an examination, if necessary to complete VA's review of the Veteran's application.

IMPORTANT - Physician please fax the completed form to _____
(VA Regional Office FAX No.)

NOTE: A list of VA Regional Office FAX Numbers can be found at www.benefits.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.