Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE) 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 ON REVERSE 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.

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

☐ YES ☐ NO

If no, how was the examination completed (check all that apply)?

☐ In-person examination
☐ Records reviewed
☐ Other, please specify:

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 DBQ and such an examination will likely provide no additional relevant evidence.

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

☐ Examination via approved video telehealth

☐ In-person examination

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. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS)?

☐ YES ☐ NO

1B. IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO ALS:

Diagnosis # 1 -	ICD code -	Date of diagnosis -
Diagnosis # 2 -	ICD code -	Date of diagnosis -
Diagnosis # 3 -	ICD code -	Date of diagnosis -

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO AMYOTROPHIC LATERAL SCLEROSIS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S ALS *(brief summary)*:

2B. DOMINANT HAND

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS

3A. DOES THE VETERAN HAVE ANY MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," report under strength testing in neurologic exam section)

3B. DOES THE VETERAN HAVE ANY PHARYNX AND/OR LARYNX AND/OR SWALLOWING CONDITIONS ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ CONSTANT INABILITY TO COMMUNICATE BY SPEECH
- ☐ SPEECH NOT INTELLIGIBLE OR INDIVIDUAL IS APHONIC
- ☐ PARALYSIS OF SOFT PALATE WITH SWALLOWING DIFFICULTY *(nasal regurgitation)* AND SPEECH IMPAIRMENT
- ☐ HOARSENESS
- ☐ MILD SWALLOWING DIFFICULTIES
- ☐ MODERATE SWALLOWING DIFFICULTIES
- ☐ SEVERE SWALLOWING DIFFICULTIES, PERMITTING PASSAGE OF LIQUIDS ONLY
- ☐ REQUIRES FEEDING TUBE DUE TO SWALLOWING DIFFICULTIES
- ☐ OTHER *(describe):* _____

3C. DOES THE VETERAN HAVE ANY RESPIRATORY CONDITIONS ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," provide PFT results under "Diagnostic Testing" Section)

3D. DOES THE VETERAN HAVE SIGNS AND/OR SYMPTOMS OF SLEEP APNEA OR SLEEP APNEA-LIKE CONDITION ATTRIBUTABLE TO ALS?

NOTE: If signs and/or symptoms of sleep apnea or sleep apnea-like condition are due to ALS, these symptoms are due to weakness in the palatal, pharyngeal, laryngeal, and/or respiratory musculature. A sleep study is not indicated to report symptoms of sleep apnea or sleep apnea-like conditions that are attributable to ALS.

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ PERSISTENT DAYTIME HYPERSOMNOLENCE
- ☐ REQUIRES USE OF BREATHING ASSISTANCE DEVICE SUCH AS CONTINUOUS AIRWAY PRESSURE (CPAP) MACHINE
- ☐ CHRONIC RESPIRATORY FAILURE WITH CARBON DIOXIDE RETENTION OR COR PULMONALE
- ☐ REQUIRES TRACHEOSTOMY

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS *(Continued)*

3E. DOES THE VETERAN HAVE ANY BOWEL IMPAIRMENT ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ SLIGHT IMPAIRMENT OF SPHINCTER CONTROL, WITHOUT LEAKAGE
- ☐ CONSTANT SLIGHT IMPAIRMENT OF SPHINCTER CONTROL, OR OCCASIONAL MODERATE LEAKAGE
- ☐ OCCASIONAL INVOLUNTARY BOWEL MOVEMENTS, NECESSITATING WEARING OF A PAD
- ☐ EXTENSIVE LEAKAGE AND FAIRLY FREQUENT INVOLUNTARY BOWEL MOVEMENTS
- ☐ TOTAL LOSS OF BOWEL SPHINCTER CONTROL
- ☐ CHRONIC CONSTIPATION
- ☐ OTHER BOWEL IMPAIRMENT *(describe):*

3F. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING URINE LEAKAGE ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ DOES NOT REQUIRE/DOES NOT USE ABSORBENT MATERIAL
- ☐ REQUIRES ABSORBENT MATERIAL THAT IS CHANGED LESS THAN 2 TIMES PER DAY
- ☐ REQUIRES ABSORBENT MATERIAL THAT IS CHANGED 2 TO 4 TIMES PER DAY
- ☐ REQUIRES ABSORBENT MATERIAL THAT IS CHANGED MORE THAN 4 TIMES PER DAY

3G. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING SIGNS AND/OR SYMPTOMS OF URINARY FREQUENCY ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ DAYTIME VOIDING INTERVAL GREATER THAN 3 HOURS
- ☐ DAYTIME VOIDING INTERVAL BETWEEN 2 AND 3 HOURS
- ☐ DAYTIME VOIDING INTERVAL BETWEEN 1 AND 2 HOURS
- ☐ DAYTIME VOIDING INTERVAL LESS THAN 1 HOUR
- ☐ NIGHTTIME AWAKENING TO VOID LESS THAN 2 TIMES
- ☐ NIGHTTIME AWAKENING TO VOID 2 TIMES
- ☐ NIGHTTIME AWAKENING TO VOID 3 TO 4 TIMES
- ☐ NIGHTTIME AWAKENING TO VOID 5 OR MORE TIMES

3H. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING FINDINGS, SIGNS AND/OR SYMPTOMS OF OBSTRUCTED VOIDING ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all signs and symptoms that apply)

- ☐ HESITANCY
  - *(If checked, is hesitancy marked?)*
  - ☐ YES ☐ NO
- ☐ SLOW OR WEAK STREAM
  - *(If checked, is stream markedly slow or weak?)*
  - ☐ YES ☐ NO
- ☐ DECREASED FORCE OF STREAM
  - *(If checked, is force of stream markedly decreased?)*
  - ☐ YES ☐ NO
- ☐ STRICTURE DISEASE REQUIRING DILATATION 1 TO 2 TIMES PER YEAR
- ☐ STRICTURE DISEASE REQUIRING PERIODIC DILATATION EVERY 2 TO 3 MONTHS
- ☐ RECURRENT URINARY TRACT INFECTIONS SECONDARY TO OBSTRUCTION
- ☐ UROFLOWMETRY PEAK FLOW RATE LESS THAN 10cc/sec
- ☐ POST VOID RESIDUALS GREATER THAN 150 cc
- ☐ URINARY RETENTION REQUIRING INTERMITTENT OR CONTINUOUS CATHETERIZATION

3I. DOES THE VETERAN HAVE VOIDING DYSFUNCTION REQUIRING THE USE OF AN APPLIANCE ATTRIBUTABLE TO ALS?

☐ YES ☐ NO *(If "Yes," describe appliance):*

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS *(Continued)*

3J. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT INFECTIONS ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all treatments that apply)

☐ NO TREATMENT

☐ LONG-TERM DRUG THERAPY

(If checked, list medications used for urinary tract infection and indicate dates for courses of treatment over the past 12 months)

_____

☐ HOSPITALIZATION

(If checked, indicate frequency of hospitalization) ☐ 1 or 2 per year ☐ More than 2 per year

☐ DRAINAGE

(If checked, indicate dates when drainage performed over past 12 months): _____

☐ OTHER MANAGEMENT/TREATMENT NOT LISTED ABOVE *(Description of management/treatment including dates of treatment)*:

_____

3K. DOES THE VETERAN *(if male)* HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO

(If "Yes," is the erectile dysfunction as likely as not (at least a 50% probability) attributable to ALS?)

☐ YES ☐ NO

(If "No," provide the etiology of the erectile dysfunction): _____

(If "Yes," is the Veteran able to achieve an erection (without medication) sufficient for penetration and ejaculation?)

☐ YES ☐ NO

(If "No," is the Veteran able to achieve an erection (with medication) sufficient for penetration and ejaculation?)

☐ YES ☐ NO

SECTION IV - NEUROLOGIC EXAM

4A. SPEECH

☐ NORMAL ☐ ABNORMAL

(If speech is abnormal, describe): _____

4B. GAIT

☐ NORMAL ☐ ABNORMAL *(describe)*: _____

(If gait is abnormal and the veteran has more than one medical condition contributing to the abnormal gait, identify the condition(s) and describe each condition's contribution to the abnormal gait): _____

4C. STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement
1/5 Visible muscle movement, but no joint movement
2/5 No movement against gravity
3/5 No movement against resistance
4/5 Less than normal strength
5/5 Normal strength

☐ ALL NORMAL

		5/5	4/5	3/5	2/5	1/5	0/5
Elbow Flexion:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Elbow Extension:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Wrist Flexion:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Wrist Extension:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Grip:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Pinch: *(thumb to index finger)*	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Knee Flexion:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Knee Extension:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Ankle Plantar Flexion:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐
Ankle Dorsiflexion:	RIGHT:	☐	☐	☐	☐	☐	☐
	LEFT:	☐	☐	☐	☐	☐	☐

SECTION IV - NEUROLOGIC EXAM *(Continued)*

4D. DEEP TENDON REFLEXES (DTRs) - RATE REFLEXES ACCORDING TO THE FOLLOWING SCALE:

0 Absent 1+ Decreased 2+ Normal 3+ Increased without clonus 4+ Increased with clonus

☐ ALL NORMAL

Biceps:	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Triceps:	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Brachioradialis:	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Knee:	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Ankle:	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+

4E. PLANTAR (Babinski) REFLEX

RIGHT: ☐ Plantar flexion (normal, or negative Babinski)
☐ Dorsiflexion (abnormal, or positive Babinski)

LEFT: ☐ Plantar flexion (normal, or negative Babinski)
☐ Dorsiflexion (abnormal, or positive Babinski)

4F. DOES THE VETERAN HAVE MUSCLE ATROPHY ATTRIBUTABLE TO ALS?

☐ YES ☐ NO *(If muscle atrophy is present, indicate location)*: _____

(When possible, provide difference measured in cm between normal and atrophied side, measured at maximum muscle bulk: _____*cm.)*

4G. SUMMARY OF MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES ATTRIBUTABLE TO ALS *(check all that apply)*:

Right upper extremity muscle weakness:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ With atrophy	☐ Complete *(no remaining function)*
Left upper extremity muscle weakness:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ With atrophy	☐ Complete *(no remaining function)*
Right lower extremity muscle weakness:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ With atrophy	☐ Complete *(no remaining function)*
Left lower extremity muscle weakness:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ With atrophy	☐ Complete *(no remaining function)*

NOTE: If the Veteran has more than one medical condition contributing to the muscle weakness, identify the condition(s) and describe each condition's contribution to the muscle weakness:

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

5A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO *(If "Yes," describe (brief summary)):*

5B. 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?

☐ YES ☐ NO

(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than or equal to 39 square cm (6 square inches)?) ***NOTE:*** *An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the Remarks section below. It is not necessary to also complete a Scars DBQ.*

☐ YES ☐ NO

(If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire.)
(If "No,' provide location and measurements of scar in centimeters.)

Location:_____ Measurements: Length_____ cm X width _____cm.

5C. COMMENTS, IF ANY:

SECTION VI - MENTAL HEALTH MANIFESTATIONS DUE TO ALS OR ITS TREATMENT

6A. DOES THE VETERAN HAVE DEPRESSION, COGNITIVE IMPAIRMENT OR DEMENTIA, OR ANY OTHER MENTAL DISORDER ATTRIBUTABLE TO ALS AND/OR ITS TREATMENT?

☐ YES ☐ NO

6B. IF YES, DOES THE VETERAN'S MENTAL DISORDER, AS IDENTIFIED IN ITEM 6A, RESULT IN GROSS IMPAIRMENT IN THOUGHT PROCESSES OR COMMUNICATION?

☐ YES ☐ NO *(If "Yes," ALSO complete the Veteran's Mental Disorder (schedule with appropriate provider)*

(If "Yes," briefly describe the Veteran's mental disorder):

SECTION VII - HOUSEBOUND

7A. IS THE VETERAN SUBSTANTIALLY CONFINED TO HIS OR HER DWELLING AND THE IMMEDIATE PREMISES *(or if institutionalized, to the ward or clinical areas)?*

☐ YES ☐ NO

(If "Yes," describe how often per day or week and under what circumstances the Veteran is able to leave the home or immediate premises):

7B. DOES THE VETERAN HAVE MORE THAN ONE CONDITION CONTRIBUTING TO HIS OR HER BEING HOUSEBOUND?

☐ YES ☐ NO *(If "Yes," list conditions and describe how each condition contributes to causing the Veteran to be housebound):*

Condition # 1: _____ Describe how condition #1 contributes to causing the Veteran to be housebound:

Condition # 2 _____ Describe how condition #2 contributes to causing the Veteran to be housebound:

Condition # 3: _____ Describe how condition #3 contributes to causing the Veteran to be housebound:

7C. IF THE VETERAN HAS ADDITIONAL CONDITIONS CONTRIBUTING TO CAUSING THE VETERAN TO BE HOUSEBOUND, LIST USING FORMAT SHOWN IN ITEM 7B?

SECTION VIII - AID AND ATTENDANCE

8A. IS THE VETERAN ABLE TO DRESS OR UNDRESS HIM OR HERSELF WITHOUT ASSISTANCE?

☐ YES ☐ NO

(If "No," is this limitation caused by the Veteran's ALS?)

☐ Yes ☐ No

8B. DOES THE VETERAN HAVE SUFFICIENT UPPER EXTREMITY COORDINATION AND STRENGTH TO BE ABLE TO FEED HIM OR HERSELF WITHOUT ASSISTANCE?

☐ YES ☐ NO

(If "No," is this limitation caused by the Veteran's ALS?)

☐ Yes ☐ No

8C. IS THE VETERAN ABLE TO ATTEND TO THE WANTS OF NATURE (toileting) WITHOUT ASSISTANCE?

☐ YES ☐ NO

(If "No," is this limitation caused by the Veteran's ALS?)

☐ Yes ☐ No

8D. IS THE VETERAN ABLE TO BATHE HIM OR HERSELF WITHOUT ASSISTANCE?

☐ YES ☐ NO

(If "No," is this limitation caused by the Veteran's ALS?)

☐ Yes ☐ No

8E. IS THE VETERAN ABLE TO KEEP HIM OR HERSELF ORDINARILY CLEAN AND PRESENTABLE WITHOUT ASSISTANCE?

☐ YES ☐ NO

(If "No," is this limitation caused by the Veteran's ALS?)

☐ Yes ☐ No

8F. DOES THE VETERAN NEED FREQUENT ASSISTANCE FOR ADJUSTMENT OF ANY SPECIAL PROSTHETIC OR ORTHOPEDIC APPLIANCE(S)

☐ YES ☐ NO *(If "Yes," describe)*:

SECTION VIII - AID AND ATTENDANCE (Continued)

NOTE: For VA purposes, "bedridden" will be that condition which actually requires that the claimant remain in bed. The fact that claimant has voluntarily taken to bed or that a physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure will not suffice.

8G. IS THE VETERAN BEDRIDDEN?

☐ YES ☐ NO

(If "Yes," is it due to the Veteran's ALS?)

☐ Yes ☐ No

8H. DOES THE VETERAN REQUIRE CARE AND/OR ASSISTANCE ON A REGULAR BASIS DUE TO HIS OR HER PHYSICAL AND/OR MENTAL DISABILITIES IN ORDER TO PROTECT HIM OR HERSELF FROM THE HAZARDS AND/OR DANGERS INCIDENT TO HIS OR HER DAILY ENVIRONMENT?

☐ YES ☐ NO

(If "Yes," is it due to the Veteran's ALS?)

☐ Yes ☐ No

8I. LIST ANY CONDITION(S), IN ADDITION TO THE VETERAN'S ALS, THAT CAUSES ANY OF THE ABOVE LIMITATIONS:

SECTION IX - NEED FOR HIGHER LEVEL *(i.e., more skilled)* AID ATTENDEANCE (A&A)

9. DOES THE VETERAN REQUIRE A IGHER, MORE SKILLED LEVE OF A&A?

☐ YES ☐ NO

NOTE: For VA purposes, this skilled, higher level care includes (but is not limited to) health-care services such as physical therapy, administration of injections, placement of indwelling catheters, changing of sterile dressings, and/or like functions which require professional health-care training or the regular supervision of a trained health-care professional to perform. In the absence of this higher level of care provided in the home, the Veteran would require hospitalization, nursing home care, or other residential institutional care.

SECTION X - ASSISTIVE DEVICES

10A. DOES THE VETERAN USE ANY ASSISTIVE DEVICE(S) AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

☐ YES ☐ NO

(If "Yes," identify assistive device(s) 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 XI - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

11A. DUE TO ALS CONDITION, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTION REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)*

☐ YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROTHESIS WOULD EQUALLY SERVE THE VETERAN

☐ NO

11B. IF YES, INDICATE EXTREMITY(IES) (Check all extremities for which this applies)

☐ RIGHT UPPER

☐ LEFT UPPER

☐ RIGHT LOWER

☐ LEFT LOWER

(For each checked extremity, describe loss of effective function, identify the condition causing loss of function, and provide specific examples) (brief summary):

SECTION XII - FINANCIAL RESPONSIBILITY

12. IN YOUR JUDGMENT, IS THE VETERAN ABLE TO MANAGE HIS OR HER BENEFIT PAYMENTS IN HIS OR HER OWN BEST INTEREST, OR ABLE TO DIRECT SOMEONE ELSE TO DO SO?

☐ YES ☐ NO *(If "No," provide rationale):*

SECTION XIII - DIAGNOSTIC TESTING

NOTE - If pulmonary function testing (PFT) is indicated due to respiratory disability, and results are in the medical record and reflect the Veteran's current respiratory function, repeat testing is not required. DLCO and bronchodilator testing is not indicated for a restrictive respiratory disability such as that caused by muscle weakness due to ALS.

13A. HAVE PFTs BEEN PERFORMED?

☐ YES ☐ NO

(If "Yes," provide most recent results, if available):

FEV-1: _____ % predicted Date of test: _____

FVC: _____ % predicted Date of test: _____

FEV-1/FVC: _____ % Date of test: _____

13B. IF PFTs HAVE BEEN PERFORMED, IS THE FLOW-VOLUME LOOP COMPATIBLE WITH UPPER AIRWAY OBSTRUCTION?

☐ YES ☐ NO

13C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

(If "Yes," provide type of test or procedure, date and results (brief summary):

SECTION XIV - FUNCTIONAL IMPACT

14. DOES THE VETERAN'S ALS IMPACT HIS OR HER ABILITY TO WORK?

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

SECTION XV - REMARKS

15. REMARKS *(If any)*

SECTION XV - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

15A. PHYSICIAN'S SIGNATURE	15B. PHYSICIAN'S PRINTED NAME	15C. DATE SIGNED

15D. PHYSICIAN'S PHONE AND FAX NUMBER	15E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	15F. PHYSICIAN'S ADDRESS

NOTE - VA may request additional medical information, including additional examinations, 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.