

INTERNAL VETERANS AFFAIRS USE
CENTRAL NERVOUS SYSTEM AND NEUROMUSCULAR DISEASES
(EXCEPT TRAUMATIC BRAIN INJURY, AMYOTROPHIC LATERAL SCLEROSIS,
PARKINSON'S DISEASE, MULTIPLE SCLEROSIS, HEADACHES, TMJ CONDITIONS,
EPILEPSY, NARCOLEPSY, PERIPHERAL NEUROPATHY, SLEEP APNEA, CRANIAL NERVE
DISORDERS, FIBROMYALGIA, CHRONIC FATIGUE SYNDROME)
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.

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 No records were reviewed
- VA claims file (hard copy paper C-file)
- VA e-folder
- CPRS
- Other (please identify other evidence reviewed):

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A CENTRAL NERVOUS SYSTEM (CNS) CONDITION?

YES NO (If "Yes," complete Item 1B)

1B. SELECT THE VETERAN'S CONDITION: (check all that apply)

CNS INFECTIONS: ICD code: _____ Date of diagnosis: _____
 Meningitis
Specify organism: _____
 Brain abscess
Specify organism: _____
 HIV
 Neurosyphilis
 Lyme disease
 Encephalitis, epidemic, chronic, including poliomyelitis, anterior (anterior horn cells)
 Other (specify): _____

VASCULAR DISEASES: ICD code: _____ Date of diagnosis: _____
 Thrombosis, TIA or cerebral infarction
 Hemorrhage (specify type): _____
 Cerebral arteriosclerosis
 Other (specify): _____

HYDROCEPHALUS: ICD code: _____ Date of diagnosis: _____
 Obstructive
 Communicating
 Normal pressure (NPH)

BRAIN TUMOR: ICD code: _____ Date of diagnosis: _____

SPINAL CORD CONDITIONS: ICD code: _____ Date of diagnosis: _____
 Syringomyelia
 Myelitis
 Hematomyelia
 Spinal Cord Injuries
 Radiation injury
 Electric or lightning injury
 Decompression sickness (DCS)
 Other (specify): _____
 Spinal cord tumor
 Other (specify): _____

BRAIN STEM CONDITIONS: ICD code: _____ Date of diagnosis: _____
 Bulbar palsy
 Pseudobulbar palsy
 Other (specify): _____

MOVEMENT DISORDERS: ICD code: _____ Date of diagnosis: _____
 Athetosis, acquired
 Myoclonus I
 Paramyoclonus multiplex (convulsive state, myoclonic type)
 Tic convulsive (Gilles de la Tourette Syndrome)
 Dystonia (specify type): _____
 Essential tremor
 Tardive dyskinesia or other neuroleptic induced syndromes
 Other (specify): _____

SECTION I - DIAGNOSIS (Continued)

1B. SELECT THE VETERAN'S CONDITION: (Continued) (check all that apply)

NEUROMUSCULAR DISORDERS: ICD code: _____ Date of diagnosis: _____

Progressive Muscular atrophy

Myasthenia gravis

Myasthenic syndrome

Botulism

Hereditary muscular disorders (specify): _____

Familial periodic paralysis

Myoglobinuria

Dermatomyositis or polymyositis (specify): _____

Other (specify): _____

INTOXICATIONS: ICD code: _____ Date of diagnosis: _____

Heavy metal intoxication (specify): _____

Solvents (specify): _____

Insecticides, pesticides, others (specify): _____

Nerve gas agents

Herbicides/defoliants (specify): _____

Other (specify): _____

OTHER CENTRAL NERVOUS CONDITION

Other diagnosis # 1 _____
ICD code: _____ Date of diagnosis: _____

Other diagnosis # 2 _____
ICD code: _____ Date of diagnosis: _____

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO CENTRAL NERVOUS SYSTEM CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S CENTRAL NERVOUS SYSTEM CONDITION(S) (Brief summary) (Continued on Page 4)

SECTION II - MEDICAL HISTORY (Continued)

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S CENTRAL NERVOUS SYSTEM CONDITION(S) (Brief summary) (Continued)

2B. DOES THE VETERAN'S CENTRAL NERVOUS SYSTEM CONDITION REQUIRE CONTINUOUS MEDICATIONS FOR CONTROL?

YES NO

IF YES, LIST MEDICATIONS USED FOR CENTRAL NERVOUS SYSTEM CONDITIONS:

2C. DOES THE VETERAN HAVE AN INFECTIOUS CONDITION?

YES NO

IF YES, IS IT ACTIVE?

Yes No

IF NO, DESCRIBE RESIDUALS IF ANY:

2D. DOMINANT HAND

RIGHT LEFT AMBIDEXTROUS

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS

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

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?

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 (*such as rigidity of the diaphragm, chest wall or laryngeal muscles*)?

YES NO

IF YES, PROVIDE PFT RESULTS IN "DIAGNOSTIC TESTING" SECTION.

3D. DOES THE VETERAN HAVE SLEEP DISTURBANCES?

YES NO

IF YES, CHECK ALL THAT APPLY:

- Insomnia
- Hypersomnolence and/or daytime "sleep attacks"
- Persistent daytime hypersomnolence
- Sleep apnea requiring the use of breathing assistance device such as continuous airway pressure (CPAP) machine
- Sleep apnea causing chronic respiratory failure with carbon dioxide retention or cor pulmonale
- Sleep apnea requiring tracheostomy

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS (Continued)

3E. DOES THE VETERAN HAVE ANY BOWEL FUNCTIONAL IMPAIRMENT?

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?

YES NO

IF YES, CHECK ONE:

- 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?

YES NO

IF YES, CHECK ALL THAT APPLY:

- | | |
|---|--|
| <input type="checkbox"/> Daytime voiding interval between 2 and 3 hours | <input type="checkbox"/> Nighttime awakening to void 2 times |
| <input type="checkbox"/> Daytime voiding interval between 1 and 2 hours | <input type="checkbox"/> Nighttime awakening to void 3 to 4 times |
| <input type="checkbox"/> Daytime voiding interval less than 1 hour | <input type="checkbox"/> Nighttime awakening to void 5 or more times |

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

YES NO

IF YES, CHECK ALL SIGNS AND SYMPTOMS THAT APPLY:

- | | |
|--|--|
| <input type="checkbox"/> Hesitancy (<i>If checked, is hesitancy marked?</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Slow or weak stream (<i>If checked, is stream markedly slow or weak?</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Decreased force of stream (<i>If checked, is force of stream markedly decreased?</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Stricture disease requiring dilatation 1 to 2 times per year | |
| <input type="checkbox"/> Stricture disease requiring periodic dilatation every 2 to 3 months | |
| <input type="checkbox"/> Recurrent urinary tract infections secondary to obstruction | |
| <input type="checkbox"/> Uroflowmetry peak flow rate less than 10 cc/sec | |
| <input type="checkbox"/> Post void residuals greater than 150 cc | |
| <input type="checkbox"/> Urinary retention requiring intermittent or continuous catheterization | |

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

YES NO

IF YES, DESCRIBE: _____

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

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*): _____

SECTION III - CONDITIONS, SIGNS, AND SYMPTOMS (Continued)

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

YES NO

IF YES, IS THE ERECTILE DYSFUNCTION AS LIKELY AS NOT (AT LEAST 50% PROBABILITY) ATTRIBUTABLE TO A CNS DISEASE (INCLUDING TREATMENT OR RESIDUALS OF TREATMENT)?

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 conditions 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

Elbow flexion: RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

Elbow extension: RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

Wrist flexion: RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

Wrist extension: RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

Grip: RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

Pinch (thumb to index finger): RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

Knee extension: RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

Ankle plantar flexion: RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

Ankle dorsiflexion: RIGHT: 5/5 4/5 3/5 2/5 1/5 0/5

LEFT: 5/5 4/5 3/5 2/5 1/5 0/5

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:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Triceps:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Brachioradialis:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Knee:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Ankle:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

4E. DOES THE VETERAN HAVE MUSCLE ATROPHY ATTRIBUTABLE TO A CNS CONDITION?

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

4F. SUMMARY OF MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES ATTRIBUTABLE TO A CNS CONDITION (*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*)

4G. 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 - TUMORS AND NEOPLASMS

5A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

YES NO

IF YES, COMPLETE THE FOLLOWING:

5B. IS THE NEOPLASM:

BENIGN MALIGNANT

5C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

YES NO; WATCHFUL WAITING

IF YES, INDICATE TYPE OF TREATMENT THE VETERAN IS CURRENTLY UNDERGOING OR HAS COMPLETED (CHECK ALL THAT APPLY):

Treatment completed; currently in watchful waiting status

Surgery - If checked, describe: _____ Date(s) of surgery: _____

Radiation therapy - Date of most recent treatment _____ Date of completion of treatment or anticipated date of completion: _____

Antineoplastic chemotherapy - Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

Other therapeutic procedure - If checked, describe procedure: _____ Date of most recent procedure: _____

Other therapeutic treatment - If checked, describe treatment: _____ Date of completion of treatment or anticipated date of completion: _____

5D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (including metastases) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

YES NO

IF YES, LIST RESIDUAL CONDITIONS AND COMPLICATIONS (*brief summary*):

5E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

6A. 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*):

6B. 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 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 Comment section below. It is not necessary to also complete a Scars DBQ.

6C. COMMENTS, IF ANY:

SECTION VII - MENTAL HEALTH MANIFESTATIONS DUE TO CNS CONDITION OR ITS TREATMENT

7A. DOES THE VETERAN HAVE DEPRESSION, COGNITIVE IMPAIRMENT OR DEMENTIA, OR ANY OTHER MENTAL HEALTH CONDITIONS ATTRIBUTABLE TO A CNS DISEASE AND/OR ITS TREATMENT?

YES NO

7B. DOES THE VETERAN'S MENTAL HEALTH CONDITION(S), AS IDENTIFIED IN THE QUESTION ABOVE, RESULT IN GROSS IMPAIRMENT IN THOUGHT PROCESSES OR COMMUNICATION?

YES NO

IF NO, ALSO COMPLETE MENTAL HEALTH QUESTIONNAIRE (*SCHEDULE WITH APPROPRIATE PROVIDER*).

IF YES, BRIEFLY DESCRIBE THE VETERAN'S MENTAL HEALTH CONDITION:

SECTION VIII - DIFFERENTIATION OF SYMPTOMS OR NEUROLOGIC EFFECTS

8. ARE YOU ABLE TO DIFFERENTIATE WHAT PORTION OF THE SYMPTOMATOLOGY OR NEUROLOGIC EFFECTS ABOVE ARE CAUSED BY EACH DIAGNOSIS?

YES NO

IF YES, LIST WHICH SYMPTOMS OR NEUROLOGIC EFFECTS ARE ATTRIBUTABLE TO EACH DIAGNOSIS, WHERE POSSIBLE:

SECTION IX - ASSISTIVE DEVICES

9. 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*):

- | | | | | |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutch(es) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

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

SECTION X - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

10. DUE TO A CNS 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 PROSTHESIS WOULD EQUALLY SERVE THE VETERAN
 NO

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 XI - DIAGNOSTIC TESTING

NOTE - If the results of MRI, other imaging studies or other diagnostic tests are in the medical record and reflect the veterans's current condition, repeat testing is not required. 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 CNS conditions.

11A. HAVE IMAGING STUDIES BEEN PERFORMED?

YES NO

IF YES, PROVIDE MOST RECENT RESULTS, IF AVAILABLE: _____

11B. HAVE PFTs BEEN PERFORMED?

YES NO

IF YES, PROVIDE MOST RECENT RESULTS, IF AVAILABLE:

FEV1: _____ % predicted Date of test: _____

FEV1/FVC: _____ % Date of test: _____

FVC _____ % predicted Date of test: _____

11C. IF PFTs HAVE BEEN PERFORMED, IS THE FLOW-VOLUME LOOP COMPATIBLE WITH UPPER AIRWAY OBSTRUCTION?

YES NO

11D. 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 XII - FUNCTIONAL IMPACT

12. DO THE VETERAN'S CENTRAL NERVOUS SYSTEM DISORDERS IMPACT HIS OR HER ABILITY TO WORK?

YES NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S CENTRAL NERVOUS SYSTEM DISORDER CONDITION(S) 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 AND FAX NUMBER

14E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

14F. MEDICAL LICENSE NUMBER AND STATE

14G. PHYSICIAN'S ADDRESS