Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
HAND AND FINGER CONDITIONS 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 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

NOTE: These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS DBQ:

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) *(Check all that apply)*:

☐ The Veteran does not have a current diagnosis associated with any claimed condition listed above. *(Explain your findings and reasons in comments section.)*

	Side affected:	ICD Code:	Date of diagnosis:
☐ Depuytren's contracture	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Trigger Finger	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Swan neck deformity	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Boutonniare deformity	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Mallet finger	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Gamekeeper's thumb	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Instability *(collateral ligament sprain, chronic)*	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Volar plate injury	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ MCP/PIP joint prostethic replacement	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Ankylosis of digit joint(s), specify joint(s): _____	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____

	Side affected:	ICD Code:	Date of diagnosis:
☐ Arthritic conditions			
☐ Arthritis, degenerative	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, gonorrheal	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, pneumococcic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, streptococcic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, syphilitic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, rheumatoid	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, traumatic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, typhoid	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, other types *(specify)* _____	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____

	Side affected:	ICD Code:	Date of diagnosis:
☐ Inflammatory conditions			
☐ Osteoporosis, with joint manifestations	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Osteomalacia	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Bones, new growths of, benign	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Osteitis deformans	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Gout	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Hydrarthrosis, intermittent	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Bursitis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Synovitis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Myositis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Periostitis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Myositis ossificans	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Tenosynovitis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____

☐ Other *(specify)*

Other diagnosis #1: _____
Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #2: _____
Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #3: _____
Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

SECTION I - DIAGNOSIS *(Continued)*

1C. COMMENTS *(if any):*

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION *(internal VA only)*?

☐ YES ☐ NO ☐ N/A

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HAND, FINGER OR THUMB CONDITION *(brief summary):*

2B. DOMINANT HAND:

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

2C. DOES THE VETERAN REPORT FLARE-UPS OF THE HAND, FINGER OR THUMB JOINTS?

☐ YES ☐ NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF THE FLARE-UPS IN HIS OR HER OWN WORDS:

2D. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE JOINT OR EXTREMITY BEING EVALUATED ON THIS DBQ INCLUDING BUT NOT LIMITED TO REPEATED USE OVER TIME?

☐ YES ☐ NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT IN HIS OR HER OWN WORDS:

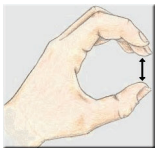
SECTION III - INITIAL RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION

There are several separate parameters requested for describing function of a joint. The question of "Does this ROM contribute to a functional loss" asks if there is a functional loss that can be ascribed to any documented loss of range of motion and unlike later questions, does not take into account the numerous other factors to be considered.

Subsequent questions take into account additional factors such as pain, fatigue, weakness, lack of endurance or incoordination. If there is pain noted on examination, it is important to understand whether or not that pain itself contributes to functional loss. Ideally a claimant would be seen immediately after that repetitive use over time or during a flare up, however, this is not always feasible.

Information regarding joint function is broken up into two subsets. First is based on repetitive use and the second functional loss associated with flare ups. The repetitive use section initially asks for objective findings after three or more repetitions of ranges of motion testing. The second portion provides a more global picture of functional loss associated with repetitive use over time. The latter takes into account medical probability of additional functional loss as a global view, taking into account not only the objective findings noted on the examination but also the subjective history provided by the claimant as well as review of available medical evidence.

Optimally, description of any additional loss of function should be provided as what the degrees range of motion would be opined to look like in these given scenarios. However, when this is not feasible, a clear as possible description of that loss should be provided. This same information (minus the three repetitions) is asked to be provided with regards to flare ups.



Instructions to the examiner for gap measurement: The position of function of the hand is with the wrist dorsiflexed 20 to 30 degrees, the metagcarpophalangeal and proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit 1) abducted and rotated so that the thumb pad faces the finger pads.

Limitation of motion of the thumb should be measured with the thumb abducted and rotated attempting to oppose the fingers. Measure the gap between the pads of the thumb and the finger pads, with the fingers considered a single unit.

3A. INITIAL RANGE OF MOTION

RIGHT HAND

- ☐ All Normal
- ☐ Abnormal or outside of normal range
- ☐ Unable to test, please explain
- ☐ Not indicated, please explain

If 'Unable to test" or "Not indicated", please explain:

	MCP	PIP	DIP
Index finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Long finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Ring finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Little finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg

	MCP	IP
Thumb		
Max extension to:	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 100 deg	_____ 90 deg

Is there a gap between the pad of the thumb and the fingers?
☐ Yes ☐ No _____cm.

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?
☐ Yes ☐ No

Index Finger _____cm.
Long Finger _____cm.

If ROM is outside of normal range, but is normal for the Veteran (for reasons other than a hand condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itself contribute to a functional loss?
☐ Yes ☐ No
If yes, please explain:

Description of Pain *(select the best response)*:
- ☐ No pain noted on exam
- ☐ Pain noted on exam on rest / non-movement
- ☐ Pain noted on exam but does not result in / cause functional loss
- ☐ Pain noted on exam and causes functional loss

If noted on exam, which ROM exhibited pain *(select all that apply)*:
- ☐ Finger flexion
- ☐ Finger extension
- ☐ Opposition with thumb

Is there evidence of pain with use of the hand?
☐ Yes ☐ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?
☐ Yes ☐ No

If yes, describe including location, severity, and relationship to condition(s).

3A. INITIAL RANGE OF MOTION *(continued)*

LEFT HAND

- ☐ All Normal
- ☐ Abnormal or outside of normal range
- ☐ Unable to test, please explain
- ☐ Not indicated, please explain

If 'Unable to test" or "Not indicated", please explain:

3A. INITIAL RANGE OF MOTION *(continued)*

LEFT HAND *(continued)*

	MCP	PIP	DIP
Index finger			
Max extension to:	0 deg	0 deg	0 deg
Max flexion to:	90 deg	100 deg	70 deg
Long finger			
Max extension to:	0 deg	0 deg	0 deg
Max flexion to:	90 deg	100 deg	70 deg
Ring finger			
Max extension to:	0 deg	0 deg	0 deg
Max flexion to:	90 deg	100 deg	70 deg
Little finger			
Max extension to:	0 deg	0 deg	0 deg
Max flexion to:	90 deg	100 deg	70 deg

	MCP	IP
Thumb		
Max extension to:	0 deg	0 deg
Max flexion to:	100 deg	90 deg

Is there a gap between the pad of the thumb and the fingers?
☐ Yes ☐ No _____cm.

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?
☐ Yes ☐ No

Index Finger _____cm.
Long Finger _____cm.

If ROM is outside of normal range, but is normal for the Veteran (for reasons other than a hand condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itself contribute to a functional loss?
☐ Yes ☐ No

If yes, please explain:

Description of Pain *(select the best response)*:
☐ No pain noted on exam
☐ Pain noted on exam on rest / non-movement
☐ Pain noted on exam but does not result in / cause functional loss
☐ Pain noted on exam and causes functional loss

If noted on exam, which ROM exhibited pain *(select all that apply)*:
☐ Finger flexion
☐ Finger extension
☐ Opposition with thumb

Is there evidence of pain with use of the hand?
☐ Yes ☐ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?
☐ Yes ☐ No

If yes, describe including location, severity, and relationship to condition(s).

3B. OBSERVED REPETITIVE USE

RIGHT HAND

Is the veteran able to perform repetitive-use testing with at least three repetitions?
☐ Yes ☐ No

If yes, perform repetitive-use testing

If no, provide reason:

Is there additional functional loss or range of motion after three repetitions?
☐ Yes ☐ No

Select all factors that cause this functional loss:
☐ N/A ☐ Weakness
☐ Pain ☐ Lack of endurance
☐ Fatigue ☐ Incoordination

Is there a gap between the pad of the thumb and the fingers?
☐ Yes ☐ No _____ cm.

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?
☐ Yes ☐ No

Index Finger _____ cm.
Long Finger _____ cm.

ROM after three repetitions

	MCP	PIP	DIP
Index finger			
Max extension to:	0 deg	0 deg	0 deg
Max flexion to:	90 deg	100 deg	70 deg
Long finger			
Max extension to:	0 deg	0 deg	0 deg
Max flexion to:	90 deg	100 deg	70 deg
Ring finger			
Max extension to:	0 deg	0 deg	0 deg
Max flexion to:	90 deg	100 deg	70 deg
Little finger			
Max extension to:	0 deg	0 deg	0 deg
Max flexion to:	90 deg	100 deg	70 deg

	MCP	IP
Thumb		
Max extension to:	0 deg	0 deg
Max flexion to:	100 deg	90 deg

3B. OBSERVED REPETITIVE USE *(continued)*

LEFT HAND

Is the veteran able to perform repetitive-use testing with at least three repetitions?

☐ Yes ☐ No

If yes, perform repetitive-use testing

If no, provide reason:

Is there additional functional loss or range of motion after three repetitions?

☐ Yes ☐ No

Select all factors that cause this functional loss:

☐ N/A ☐ Weakness
☐ Pain ☐ Lack of endurance
☐ Fatigue ☐ Incoordination

Is there a gap between the pad of the thumb and the fingers?

☐ Yes ☐ No _____ cm.

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?

☐ Yes ☐ No

Index Finger _____ cm.
Long Finger _____ cm.

ROM after three repetitions

	MCP	PIP	DIP
Index finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Long finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Ring finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Little finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg

	MCP	IP
Thumb		
Max extension to:	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 100 deg	_____ 90 deg

3C. REPEATED USE OVER TIME

RIGHT HAND

Is the Veteran being examined immediately after repetitive use over time?

☐ Yes ☐ No

If the examination is ***not*** being conducted immediately after repetitive use over time:

☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time.
☐ The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. Please explain.
☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.

If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☐ Unable to say without mere speculation

If unable to say without mere speculation, please explain:

Select all factors that cause this functional loss:

☐ N/A ☐ Weakness
☐ Pain ☐ Lack of endurance
☐ Fatigue ☐ Incoordination

Are you able to describe in terms of Range of Motion?

☐ Yes ☐ No

If no, please describe:

	MCP	PIP	DIP
Index finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Long finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Ring finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Little finger			
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg

	MCP	IP
Thumb		
Max extension to:	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 100 deg	_____ 90 deg

Is there a gap between the pad of the thumb and the fingers?

☐ Yes ☐ No _____ cm.

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?

☐ Yes ☐ No

Index Finger _____ cm.
Long Finger _____ cm.

3C. REPEATED USE OVER TIME *(continued)*

LEFT HAND

Is the Veteran being examined immediately after repetitive use over time?

☐ Yes ☐ No

If the examination is ***not*** being conducted immediately after repetitive use over time:

☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time.

☐ The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. Please explain.

☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.

If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☐ Unable to say without mere speculation

If unable to say without mere speculation, please explain:

Select all factors that cause this functional loss:

☐ N/A ☐ Weakness

☐ Pain ☐ Lack of endurance

☐ Fatigue ☐ Incoordination

Are you able to describe in terms of Range of Motion?

☐ Yes ☐ No

If no, please describe:

Index finger	MCP	PIP	DIP
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Long finger	MCP	PIP	DIP
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Ring finger	MCP	PIP	DIP
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Little finger	MCP	PIP	DIP
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Thumb	MCP	IP	
Max extension to:	_____ 0 deg	_____ 0 deg	
Max flexion to:	_____ 100 deg	_____ 90 deg	

Is there a gap between the pad of the thumb and the fingers?

☐ Yes ☐ No _____ cm.

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?

☐ Yes ☐ No

Index Finger _____ cm.

Long Finger _____ cm.

3D. FLARE UPS

RIGHT HAND

Is the exam being conducted during a flare up?

☐ Yes ☐ No

If the examination is ***not*** being conducted during a flare up:

☐ The examination is medically consistent with the Veteran's statements describing functional loss during flare up.

☐ The examination is medically inconsistent with the Veteran's statements describing functional loss during flare up. Please explain.

☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.

If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☐ Unable to say without mere speculation

If unable to say without mere speculation, please explain:

Select all factors that cause this functional loss:

☐ N/A ☐ Weakness

☐ Pain ☐ Lack of endurance

☐ Fatigue ☐ Incoordination

Are you able to describe in terms of Range of Motion?

☐ Yes ☐ No

If no, please describe:

Index finger	MCP	PIP	DIP
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Long finger	MCP	PIP	DIP
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Ring finger	MCP	PIP	DIP
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Little finger	MCP	PIP	DIP
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg
Thumb	MCP	IP	
Max extension to:	_____ 0 deg	_____ 0 deg	
Max flexion to:	_____ 100 deg	_____ 90 deg	

Is there a gap between the pad of the thumb and the fingers?

☐ Yes ☐ No _____ cm.

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?

☐ Yes ☐ No

Index Finger _____ cm.

Long Finger _____ cm.

3D. FLARE UPS *(continued)*

LEFT HAND

Is the exam being conducted during a flare up?

☐ Yes ☐ No

If the examination is ***not*** being conducted during a flare up:

☐ The examination is medically consistent with the Veteran's statements describing functional loss during flare up.

☐ The examination is medically inconsistent with the Veteran's statements describing functional loss during flare up. Please explain.

☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.

If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☐ Unable to say without mere speculation

If unable to say without mere speculation, please explain:

Select all factors that cause this functional loss:

☐ N/A ☐ Weakness

☐ Pain ☐ Lack of endurance

☐ Fatigue ☐ Incoordination

Are you able to describe in terms of Range of Motion?

☐ Yes ☐ No

If no, please describe:

	MCP	PIP	DIP	PAIN?
Index finger				
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg	
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg	
Long finger	MCP	PIP	DIP	
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg	
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg	
Ring finger	MCP	PIP	DIP	
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg	
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg	
Little finger	MCP	PIP	DIP	
Max extension to:	_____ 0 deg	_____ 0 deg	_____ 0 deg	
Max flexion to:	_____ 90 deg	_____ 100 deg	_____ 70 deg	
Thumb	MCP	IP		
Max extension to:	_____ 0 deg	_____ 0 deg		
Max flexion to:	_____ 100 deg	_____ 90 deg		

Is there a gap between the pad of the thumb and the fingers?

☐ Yes ☐ No _____ cm.

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?

☐ Yes ☐ No

Index Finger _____ cm.

Long Finger _____ cm.

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABIITY

RIGHT HAND

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

☐ None

☐ Less movement than normal due to ankylosis, adhesions, etc.

☐ More movement than normal due to flail joints, fracture non-unions, etc.

☐ Weakened movements due to muscle or peripheral nerves injury, etc.

☐ Other, please describe:

☐ Swelling

☐ Deformity

☐ Atrophy of disuse

☐ Instability of station

LEFT HAND

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

☐ None

☐ Less movement than normal due to ankylosis, adhesions, etc.

☐ More movement than normal due to flail joints, fracture non-unions, etc.

☐ Weakened movement due to muscle or peripheral nerves injury, etc.

☐ Other, please describe additional contributing factors of disability:

☐ Swelling

☐ Deformity

☐ Atrophy of disuse

☐ Instability of station

SECTION IV- MUSCLE STRENGTH TESTING

4A. MUSCLE STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

HAND GRIP:		RIGHT /5	If the Veteran has a reduction in muscle strength, is it due to a diagnosis listed in Section 1? ☐ Yes ☐ No IF NO, PROVIDE RATIONALE:
		LEFT /5	

4B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

☐ YES ☐ NO

IF YES, IS THE MUSCLE ATROPHY DUE TO A DIAGNOSIS LISTED IN SECTION 1?

☐ YES ☐ NO

IF NO, PROVIDE RATIONALE:

FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSIS LISTED IN SECTION 1, INDICATE SIDE AND SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK.

LOCATION OF MUSCLE ATROPHY:

☐ RIGHT UPPER EXTREMITY *(specify location of measurement)*:

_____

CIRCUMFERENCE OF MORE NORMAL SIDE: _____ cm CIRCUMFERENCE OF ATROPHIED SIDE: _____ cm

☐ LEFT UPPER EXTREMITY *(specify location of measurement)*:

_____

CIRCUMFERENCE OF MORE NORMAL SIDE: _____ cm CIRCUMFERENCE OF ATROPHIED SIDE: _____ cm

4C. COMMENTS, IF ANY:

SECTION V - ANKYLOSIS

COMPLETE THIS SECTION IF THE VETERAN HAS ANKYLOSIS OF ANY THUMB OR FINGER JOINTS

NOTE: Ankylosis is the immobilization and consolidation of a joint due to disease, injury or surgical procedure.

5A. INDICATE LOCATION, SEVERITY AND SIDE AFFECTED *(check all that apply)*:

RIGHT HAND:

☐ No ankylosis	Name of joint	Is it ankylosed?	If ankylosed, what is the position of ankylosis	If ankylosed, is there rotation of a bone?	If ankylosed, is there angulation of a bone?
Thumb ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	IP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
Index Finger ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	PIP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
Long Finger ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	PIP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
Ring Finger ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	PIP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
Little Finger ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	PIP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No

LEFT HAND:

☐ No ankylosis	Name of joint	Is it ankylosed?	If ankylosed, what is the position of ankylosis	If ankylosed, is there rotation of a bone?	If ankylosed, is there angulation of a bone?
Thumb ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	IP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
Index Finger ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	PIP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
Long Finger ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	PIP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
Ring Finger ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	PIP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
Little Finger ☐ No ankylosis	MCP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No
	PIP	☐ Yes ☐ No	☐ In extension ☐ In full flexion ☐ Other, degrees of flexion	☐ Yes ☐ No	☐ Yes ☐ No

SECTION V - ANKYLOSIS *(continued)*

5B. DOES THE ANKYLOSIS RESULT IN LIMITATION OF MOTION OF OTHER DIGITS OR INTERFERENCE WITH OVERALL FUNCTION OF THE HAND?

☐ YES ☐ NO IF YES, PLEASE DESCRIBE AND PROVIDE RATIONALE FOR YOUR RESPONSE:

5C. COMMENTS, IF ANY:

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 ANY 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 THE 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 - ASSISTIVE DEVICES

7A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES?

☐ YES ☐ NO IF YES, IDENTIFY ASSISTIVE DEVICES USED *(check all that apply and indicate frequency):*

☐ Brace Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

☐ Other: _____ Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

7B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

8. DUE TO THE VETERAN'S HAND, FINGER OR THUMB CONDITIONS, 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

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES: ☐ RIGHT UPPER ☐ LEFT UPPER

FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES *(brief summary)*:

NOTE: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prothesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

SECTION IX - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, even if in the past, no further imaging studies are required by VA, even if arthritis has worsened.

9A. HAVE IMAGING STUDIES OF THE HANDS BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, ARE THERE ABNORMAL FINDINGS?

☐ YES ☐ NO

IF YES, INDICATE FINDINGS:

☐ DEGENERATIVE OR TRAUMATIC ARTHRITIS HAND: ☐ RIGHT ☐ LEFT ☐ BOTH

IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED IN MULTIPLE JOINTS OF THE SAME HAND, INCLUDING THUMB AND FINGERS?

☐ YES ☐ NO

IF YES, INDICATE HAND: ☐ RIGHT ☐ LEFT ☐ BOTH

☐ OTHER. DESCRIBE: _____ HAND: ☐ RIGHT ☐ LEFT ☐ BOTH

9B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS OR RESULTS?

☐ YES ☐ NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

9C. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

SECTION X - FUNCTIONAL IMPACT

NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

10. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK *(such as standing, walking, lifting, sitting, etc.)*?

☐ YES ☐ NO IF YES, DESCRIBE THE FUNCTIONAL IMPACT OF EACH CONDITION, PROVIDING ONE OR MORE EXAMPLES:

SECTION XI - REMARKS

11. REMARKS, IF ANY:

SECTION XII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

12A. PHYSICIAN'S SIGNATURE	12B. PHYSICIAN'S PRINTED NAME	12C. DATE SIGNED

12D. PHYSICIAN'S PHONE NUMBER	12E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	12F. 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.

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 required to obtain or retain benefits. 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.