Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
WRIST 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:
☐ Wrist Sprain, Chronic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Tendinitis, wrist	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Ganglion cyst	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Carpal metacarpal *(CMC)* arthritis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Osteoarthritis arthritis, wrist	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ deQuervain's syndrome	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Triangular fibrocartilaginous complex *(TFCC)* injury	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Carpal instability *(intercalated segment/ midcarpal/scapholunate dissociation)*	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Avascular necrosis of carpal bones	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Wrist arthroplasty *(total/ulnar head replacement)*	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Ankylosis of wrist	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____

☐ Arthritic conditions	Side affected:	ICD Code:	Date of diagnosis:
☐ 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: _____

☐ Inflammatory conditions	Side affected:	ICD Code:	Date of diagnosis:
☐ 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: _____
☐ Inflammatory, other types *(specify)* _____	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____

☐ Other *(specify)*

Other diagnosis #1: _____

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

Other *(continued)*

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: _____

If there are additional diagnoses that pertain to wrist conditions, list using above format:

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 WRIST CONDITION *(brief summary):*

2B. DOMINANT HAND:

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

2C. DOES THE VETERAN REPORT FLARE-UPS OF THE WRIST?

☐ 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 *(regardless of repetitive use)*?

☐ YES ☐ NO

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

SECTION III - 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 on 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.

3A. INITIAL ROM MEASUREMENTS

RIGHT WRIST

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

☐ Abnormal or outside of normal range ☐ Not indicated

Palmar Flexion (0-80 degrees): _____ to _____ degrees Ulnar Deviation (0-45 degrees): _____ to _____ degrees

Dorsiflexion (0-70 degrees): _____ to _____ degrees Radial Deviation (0-20 degrees): _____ to _____ degrees

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a wrist 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 examination and causes functional loss

If noted on examination, which ROM exhibited pain *(select all that apply)*:

☐ Palmar Flexion ☐ Ulnar Deviation

☐ Dorsiflexion ☐ Radial Deviation

Is there evidence of pain with weight bearing?

☐ Yes ☐ No

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

If yes, please explain. Include location, severity, and relationship to condition(s).

Is there objective evidence of crepitus?

☐ Yes ☐ No

LEFT WRIST

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

☐ Abnormal or outside of normal range ☐ Not indicated

Palmar Flexion (0-80 degrees): _____ to _____ degrees Ulnar Deviation (0-45 degrees): _____ to _____ degrees

Dorsiflexion (0-70 degrees): _____ to _____ degrees Radial Deviation (0-20 degrees): _____ to _____ degrees

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a wrist 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 examination and causes functional loss

If noted on examination, which ROM exhibited pain *(select all that apply)*:

☐ Palmar Flexion ☐ Ulnar Deviation

☐ Dorsiflexion ☐ Radial Deviation

Is there evidence of pain with weight bearing?

☐ Yes ☐ No

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

If yes, please explain. Include location, severity, and relationship to condition(s).

Is there objective evidence of crepitus?

☐ Yes ☐ No

3B. OBSERVED REPETITIVE USE

Wrist	Is the veteran able to perform repetitive-use testing with at least three repetitions?	Is there additional loss of function or range of motion after three repetitions?	Joint Movement	ROM after 3 repetitions:
RIGHT WRIST	☐ Yes ☐ No If yes, perform repetitive-use testing If no, provide reason:	☐ Yes ☐ No If yes, report ROM after a minimum of 3 repetitions. If no, documentation of ROM after repetitive-use testing is not required.	Palmar Flexion (0-80 degrees)	_____ to _____
			Dorsiflexion (0-70 degrees):	_____ to _____
			Ulnar Deviation (0-45 degrees):	_____ to _____
			Radial Deviation (0-20 degrees):	_____ to _____
	Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination			

Wrist	Is the veteran able to perform repetitive-use testing with at least three repetitions?	Is there additional loss of function or range of motion after three repetitions?	Joint Movement	ROM after 3 repetitions:
LEFT WRIST	☐ Yes ☐ No If yes, perform repetitive-use testing If no, provide reason:	☐ Yes ☐ No If yes, report ROM after a minimum of 3 repetitions. If no, documentation of ROM after repetitive-use testing is not required.	Palmar Flexion (0-80 degrees):	_____ to _____
			Dorsiflexion (0-70 degrees):	_____ to _____
			Ulnar Deviation (0-45 degrees):	_____ to _____
			Radial Deviation (0-20 degrees):	_____ to _____
	Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination			

3C. REPEATED USE OVER TIME

Wrist	Is the Veteran being examined immediately after repetitive use over time?	If the examination is ***not*** being conducted immediately after repetitive use over time:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
RIGHT WRIST	☐ Yes ☐ No	☐ The examination is medically consistent 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. ☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.	
	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 ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination		
	Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No	If no, please describe:	
	Palmar Flexion (0-80 degrees): _____ to _____ degrees Dorsiflexion (0-70 degrees): _____ to _____ degrees Ulnar Deviation (0-45 degrees): _____ to _____ degrees Radial Deviation (0-20 degrees): _____ to _____ degrees		

Wrist	Is the Veteran being examined immediately after repetitive use over time?	If the examination is ***not*** being conducted immediately after repetitive use over time:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
LEFT WRIST	☐ Yes ☐ No	☐ 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. ☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.	
	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:	

LEFT WRIST *(continued)*	Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination	
	Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No	If no, please describe:
	Palmar Flexion (0-80 degrees): _____ to _____ degrees Dorsiflexion (0-70 degrees): _____ to _____ degrees Ulnar Deviation (0-45 degrees): _____ to _____ degrees Radial Deviation (0-20 degrees): _____ to _____ degrees	

3D. FLARE UPS

Wrist	Is the examination being conducted during a flare up?	If the examination is ***not*** being conducted during a flare up:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
RIGHT WRIST	☐ Yes ☐ No	☐ 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. ☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.	
	Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare ups? ☐ 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 ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination		
	Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No	If no, please describe:	
	Palmar Flexion (0-80 degrees): _____ to _____ degrees Dorsiflexion (0-75 degrees): _____ to _____ degrees Ulnar Deviation (0-45 degrees): _____ to _____ degrees Radial Deviation (0-20 degrees): _____ to _____ degrees		

Wrist	Is the examination being conducted during a flare up?	If the examination is ***not*** being conducted during a flare up:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
LEFT WRIST	☐ Yes ☐ No	☐ 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. ☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.	
	Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare ups? ☐ 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 ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination		
	Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No	If no, please describe:	
	Palmar Flexion (0-80 degrees): _____ to _____ degrees Dorsiflexion (0-70 degrees): _____ to _____ degrees Ulnar Deviation (0-45 degrees): _____ to _____ degrees Radial Deviation (0-20 degrees): _____ to _____ degrees		

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABIITY

RIGHT SIDE

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, limitation or blocking, adhesions, tendon-tie-ups, contracted scars, etc.)*
☐ More movement than normal *(from flail joints, resections, nonunion of fractures, relaxation of ligaments, etc..)*
☐ Weakened movement *(due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.)*

☐ Swelling
☐ Deformity
☐ Atrophy of disuse
☐ Instability of station

☐ Disturbance of locomotion
☐ Interference with sitting
☐ Interference with standing

☐ Other, describe:

LEFT SIDE

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, limitation or blocking, adhesions, tendon-tie-ups, contracted scars, etc.)*
☐ More movement than normal *(from flail joints, resections, nonunion of fractures, relaxation of ligaments, etc..)*
☐ Weakened movement *(due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.)*

☐ Swelling
☐ Deformity
☐ Atrophy of disuse
☐ Instability of station

☐ Disturbance of locomotion
☐ Interference with sitting
☐ Interference with standing

☐ Other, describe:

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

Wrist	Flexion /Extension	Rate Strength	Is there a reduction in muscle strength?	If yes, is the reduction entirely due to the claimed condition in the Diagnosis section?	If no (the reduction is not entirely due to the claimed condition), provide rationale:
RIGHT WRIST	Flexion	/5	☐ Yes ☐ No	☐ Yes ☐ No	
	Extension	/5			
LEFT WRIST	Flexion	/5	☐ Yes ☐ No	☐ Yes ☐ No	
	Extension	/5			

4B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

☐ YES ☐ NO

IF YES, IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO IF NO, PROVIDE RATIONALE:

FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSES 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 such as "10cm above or below elbow")*:

_____

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

SECTION VII - MUSCLE STRENGTH TESTING *(Continued)*

☐ LEFT UPPER EXTREMITY *(specify location of measurement such as "10cm above or below elbow")*:

_____

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

4C. COMMENTS, IF ANY:

SECTION V - ANKYLOSIS

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

COMPLETE THIS SECTION IF THE VETERAN HAS ANKYLOSIS OF THE WRIST.

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

RIGHT SIDE:

☐ No ankylosis

☐ Favorable in 20º to 30º dorsiflexion

☐ Extremely unfavorable

☐ Unfavorable, with ulnar deviation
If checked, provide degrees of ulnar deviation: _____

☐ Unfavorable, with radial deviation
If checked, provide degrees of radial deviation: _____

☐ Unfavorable, in any degree of palmar flexion
If checked, provide degrees of palmar flexion: _____

☐ Any other position except favorable
If checked, describe: _____

LEFT SIDE:

☐ No ankylosis

☐ Favorable in 20º to 30º dorsiflexion

☐ Extremely unfavorable

☐ Unfavorable, with ulnar deviation
If checked, provide degrees of ulnar deviation: _____

☐ Unfavorable, with radial deviation
If checked, provide degrees of radial deviation: _____

☐ Unfavorable, in any degree of palmar flexion
If checked, provide degrees of palmar flexion: _____

☐ Any other position except favorable
If checked, describe: _____

5B. COMMENTS, IF ANY:

SECTION VI - SURGICAL PROCEDURES

6. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED *(check all that apply)*:

RIGHT SIDE:

☐ TOTAL WRIST JOINT REPLACEMENT
DATE OF SURGERY: _____
RESIDUALS:
- ☐ None
- ☐ Intermediate degrees of residual weakness, pain or limitation of motion
- ☐ Chronic residuals consisting of severe painful motion or weakness
- ☐ Other, describe:

☐ ARTHROSCOPIC OR OTHER WRIST SURGERY
TYPE OF SURGERY: _____
DATE OF SURGERY: _____

☐ RESIDUALS OF ARTHROSCOPIC OR OTHER WRIST SURGERY
DESCRIBE RESIDUALS:

LEFT SIDE:

☐ TOTAL WRIST JOINT REPLACEMENT
DATE OF SURGERY: _____
RESIDUALS:
- ☐ None
- ☐ Intermediate degrees of residual weakness, pain or limitation of motion
- ☐ Chronic residuals consisting of severe painful motion or weakness
- ☐ Other, describe:

☐ ARTHROSCOPIC OR OTHER WRIST SURGERY
TYPE OF SURGERY: _____
DATE OF SURGERY: _____

☐ RESIDUALS OF ARTHROSCOPIC OR OTHER WRIST SURGERY
DESCRIBE RESIDUALS:

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

7A. 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*):

7B. 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?

☐ 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: 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 Comment section below. It is not necessary to also complete a Scars DBQ.

7C. COMMENTS, IF ANY:

SECTION VIII - ASSISTIVE DEVICES

8A. 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

8B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION IX - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

DUE TO THE VETERAN'S WRIST CONDITIONS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAIN 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 X - 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.

10A. HAVE IMAGING STUDIES OF THE WRIST BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

☐ YES ☐ NO IF YES, INDICATE WRIST: ☐ RIGHT ☐ LEFT ☐ BOTH

SECTION X - DIAGNOSTIC TESTING *(Continued)*

10B. 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)*:

10C. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

SECTION XI - 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.

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 XII - REMARKS

12. REMARKS, IF ANY:

SECTION XIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

13A. PHYSICIAN'S SIGNATURE	13B. PHYSICIAN'S PRINTED NAME	13C. DATE SIGNED

13D. PHYSICIAN'S PHONE & FAX NUMBERS	13E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	13F. 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.