

**AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE)
DISABILITY BENEFITS QUESTIONNAIRE**

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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.

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL Questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Other, please describe:

Are you a VA Healthcare provider? Yes No

Is the Veteran regularly seen as a patient in your clinic? Yes No

Was the Veteran examined in person? Yes No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

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)

- | | |
|---|--|
| <input type="checkbox"/> DAYTIME VOIDING INTERVAL GREATER THAN 3 HOURS | <input type="checkbox"/> NIGHTTIME AWAKENING TO VOID LESS THAN 2 TIMES |
| <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 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	2/5 No movement against gravity	4/5 Less than normal strength
1/5 Visible muscle movement, but no joint movement	3/5 No movement against resistance	5/5 Normal strength

<input type="checkbox"/> ALL NORMAL	Elbow Flexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Elbow Extension:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Wrist Flexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Wrist Extension:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Grip:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Pinch: (thumb to index finger)	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Knee Flexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Knee Extension:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Ankle Plantar Flexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Ankle Dorsiflexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
		LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 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. 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:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> With atrophy	<input type="checkbox"/> Complete (no remaining function)
Left upper extremity muscle weakness:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> With atrophy	<input type="checkbox"/> Complete (no remaining function)
Right lower extremity muscle weakness:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> With atrophy	<input type="checkbox"/> Complete (no remaining function)
Left lower extremity muscle weakness:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> With atrophy	<input type="checkbox"/> 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 UNDESS 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 HIGHER, MORE SKILLED LEVEL 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)):

<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 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