



Name of Claimant/Veteran:

Claimant/Veteran's Social Security Number:

Date of Examination:

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.

DOMINANT HAND

Dominant hand: Right Left Ambidextrous

SECTION I - DIAGNOSIS

1A. Has the Veteran had any amputations?

Yes No

1B. If yes, provide only diagnoses that pertain to amputations.

Amputation # 1 -	ICD Code -	Date of amputation
Amputation # 2 -	ICD Code -	Date of amputation -
Amputation # 3 -	ICD Code -	Date of amputation -

1C. If additional amputation(s) exist, list using above format.

SECTION II - MEDICAL HISTORY

2A. Describe the history (including etiology and course) of each amputation listed above.

SECTION III - AMPUTATION(S) SITE(S)

3A. Amputation(s) sites(s) (Indicate affected sites):

- Upper extremities (not including the fingers)
- Fingers
- Lower extremities (not including the toes)
- Toes

For all checked sites, complete the corresponding sections below.

SECTION IV - UPPER EXTREMITIES (NOT INCLUDING FINGERS)

4A. Does the Veteran have an amputation of either arm?

Yes No If yes, indicate site and side affected. Check all that apply.

- | | | | |
|--|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Amputation is below insertion of deltoid | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation is above insertion of deltoid | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula) | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Forequarter amputation (involving complete removal of the humerus along with any portion of the clavicle) | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Forequarter amputation (involving complete removal of the humerus along with any portion of the ribs) | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Disarticulation (involving complete removal of the humerus only) | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |

4B. Indicate if the upper extremity amputation site allows the use of a suitable prosthetic appliance.

Left Yes No NA

Right Yes No NA

4C. Is there an amputation of either forearm?

Yes No If yes, indicate site and side affected. Check all that apply.

- | | | | |
|--|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Amputation below insertion of pronator teres | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation above insertion of pronator teres | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation resulting in loss of use of the hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |

SECTION V - FINGERS

5A. Does the Veteran have an amputation of either thumb?

Yes No If yes, indicate site and side affected. Check all that apply.

- | | | | |
|--|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Amputation at the distal joint or through the distal phalanx | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation at the metacarpophalangeal joint or through the proximal phalanx | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation with metacarpal resection | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |

5B. Does the Veteran have an amputation of any fingers?

Yes No If yes, indicate site and side affected. Check all that apply.

- Other (such as a fingertip amputation) please describe in Section VIII
- Amputation through the middle phalanx or at the distal joint
- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Right index finger | <input type="checkbox"/> Right long finger | <input type="checkbox"/> Right ring finger | <input type="checkbox"/> Right little finger |
| <input type="checkbox"/> Left index finger | <input type="checkbox"/> Left long finger | <input type="checkbox"/> Left ring finger | <input type="checkbox"/> Left little finger |
| <input type="checkbox"/> Both index fingers | <input type="checkbox"/> Both long fingers | <input type="checkbox"/> Both ring fingers | <input type="checkbox"/> Both little fingers |
- Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto
- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Right index finger | <input type="checkbox"/> Right long finger | <input type="checkbox"/> Right ring finger | <input type="checkbox"/> Right little finger |
| <input type="checkbox"/> Left index finger | <input type="checkbox"/> Left long finger | <input type="checkbox"/> Left ring finger | <input type="checkbox"/> Left little finger |
| <input type="checkbox"/> Both index fingers | <input type="checkbox"/> Both long fingers | <input type="checkbox"/> Both ring fingers | <input type="checkbox"/> Both little fingers |
- Amputation with metacarpal resection (more than one-half the bone lost)
- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Right index finger | <input type="checkbox"/> Right long finger | <input type="checkbox"/> Right ring finger | <input type="checkbox"/> Right little finger |
| <input type="checkbox"/> Left index finger | <input type="checkbox"/> Left long finger | <input type="checkbox"/> Left ring finger | <input type="checkbox"/> Left little finger |
| <input type="checkbox"/> Both index fingers | <input type="checkbox"/> Both long fingers | <input type="checkbox"/> Both ring fingers | <input type="checkbox"/> Both little fingers |

SECTION VI - LOWER EXTREMITIES (NOT INCLUDING THE TOES)

6A. Does the Veteran have an above the knee amputation of the thigh?

Yes No If yes, indicate site and side affected. Check all that apply.

- | | | | |
|--|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Amputation of the middle or lower third | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation of the upper third, one-third of the distance from the perineum to the knee joint, measured from the perineum | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only) | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones) | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |

6B. Indicate if the thigh amputation site allows the use of a suitable prosthetic appliance.

- | | | | |
|-------|------------------------------|-----------------------------|-----------------------------|
| Left | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| Right | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |

6C. Does the Veteran have a below or through the knee amputation of the lower leg, including forefoot?

Yes No If yes, indicate site and side affected. Check all that apply.

- | | | | |
|--|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Amputation of the forefoot, which is proximal to the metatarsal bones (more than one-half of metatarsal loss) | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation between the forefoot and knee, permitting prosthesis | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation not improvable by prosthesis controlled by natural knee action | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Amputation with defective stump and amputation of the thigh recommended | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both |

6D. Indicate if the lower leg amputation site allows the use of a suitable prosthetic appliance.

- | | | | |
|-------|------------------------------|-----------------------------|-----------------------------|
| Left | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| Right | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |

SECTION VII - TOES

7A. Does the Veteran have an amputation of any toes?

Yes No If yes, indicate site and side affected. Check all that apply.

Amputation of toes without metatarsal loss or transmetatarsal loss.

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Right great toe | <input type="checkbox"/> Right 2nd toe | <input type="checkbox"/> Right 3rd toe | <input type="checkbox"/> Right 4th toe | <input type="checkbox"/> Right little toe |
| <input type="checkbox"/> Left great toe | <input type="checkbox"/> Left 2nd toe | <input type="checkbox"/> Left 3rd toe | <input type="checkbox"/> Left 4th toe | <input type="checkbox"/> Left little toe |
| <input type="checkbox"/> Both great toes | <input type="checkbox"/> Both 2nd toes | <input type="checkbox"/> Both 3rd toes | <input type="checkbox"/> Both 4th toes | <input type="checkbox"/> Both little toes |

Amputation of toes with up to half metatarsal loss or transmetatarsal loss.

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Right great toe | <input type="checkbox"/> Right 2nd toe | <input type="checkbox"/> Right 3rd toe | <input type="checkbox"/> Right 4th toe | <input type="checkbox"/> Right little toe |
| <input type="checkbox"/> Left great toe | <input type="checkbox"/> Left 2nd toe | <input type="checkbox"/> Left 3rd toe | <input type="checkbox"/> Left 4th toe | <input type="checkbox"/> Left little toe |
| <input type="checkbox"/> Both great toes | <input type="checkbox"/> Both 2nd toes | <input type="checkbox"/> Both 3rd toes | <input type="checkbox"/> Both 4th toes | <input type="checkbox"/> Both little toes |

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

8A. 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).

8B. Does the Veteran have any scars or other disfigurement of the skin related to any conditions or to the treatment of any conditions listed in the diagnosis section above?

Yes No If yes, also complete the appropriate dermatological questionnaire.

SECTION IX- ASSISTIVE DEVICES

9A. Does the Veteran use any assistive devices? Yes No

If Yes, identify the assistive devices 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, indicate the side, and identify the assistive device used for each condition.

SECTION X - DIAGNOSTIC TESTING

Note - Imaging studies are not required to document amputations.

10A. Are there any significant diagnostic test findings and/or results?

Yes No If yes, provide type of test or procedure, date and results - brief summary:

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.

11A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/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

12A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

13A. Examiner's signature:

13B. Examiner's printed name:

13C. Date signed:

13D. Examiner's phone/fax number:

13E. National Provider Identifier (NPI) number:

13F. Medical license number and state:

13G. Examiner's address: