

HAND AND FINGERS
DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran

Patient/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 completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

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

Veteran/Claimant

Third party (please list name(s) of organization(s) or individual(s))

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

Note: These are condition(s) for which an evaluation has been requested on the 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 questionnaire:

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(s), explain your findings and reasons in the Remarks 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(s) listed above. (Explain your findings and reasons in the Remarks section)

		Side affected:	ICD Code:	Date of diagnosis:
<input type="checkbox"/> Dupuytren's contracture	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Trigger finger	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Swan neck deformity	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Boutonniere deformity	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Mallet finger	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Gamekeeper's thumb	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Instability (chronic collateral ligament sprain)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Volar plate injury	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> MCP/PIP joint prosthetic replacement	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Ankylosis of digit joint(s), specify joint(s)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
 <hr/>				
<input type="checkbox"/> Degenerative arthritis, other than posttraumatic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Arthritis, gonorrheal	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Arthritis, pneumococcic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Arthritis, streptococcic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Arthritis, syphilitic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Arthritis, rheumatoid (multi-joint)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Post-traumatic arthritis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Arthritis, typhoid	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (specify)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
 <hr/>				
<input type="checkbox"/> Osteoporosis, residuals of	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Osteomalacia, residuals of	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Bones, neoplasm, benign	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Osteitis deformans	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Gout	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Bursitis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Myositis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Heterotopic ossification	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	
<input type="checkbox"/> Tendinitis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____	

<input type="checkbox"/> Tendinosis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Tenosynovitis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Inflammatory other types (specify) _____	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Other (specify) _____					
Other diagnosis #1 _____					
<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both Right: _____ Left: _____					
Other diagnosis #2 _____					
<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both Right: _____ Left: _____					

1C. If there are additional diagnoses that pertain to hand and finger conditions, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's hand, finger or thumb condition (brief summary):

2B. Does the Veteran report flare-ups of the hand, finger or thumb? Yes No

If yes, document the Veteran's description of the flare-ups he or she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity and/or extent of functional impairment he or she experiences during a flare-up of symptoms.

2C. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this questionnaire, including but not limited to after repeated use over time? Yes No

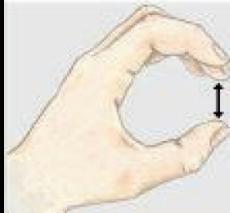
If yes, document the Veteran's description of functional loss or functional impairment in his/her own words.

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

There are several separate parameters requested for describing function of a joint. The question "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 repetitive use over time or during a flare-up; however, this is not always feasible.

Information regarding joint function on repetitive use is broken up into two subsets. The first subset is based on observed repetitive use, and the second is based on functional loss associated with repeated use over time. The observed repetitive use section initially asks for objective findings after three or more repetitions of range of motion testing. The second subset 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. This takes 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 the available medical evidence.

Optimally, a description of any additional loss of function should be provided - such as what the degrees of range of motion would be opined to look like after repetitive use over time. However, when this is not feasible, an "as 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 metacarpophalangeal and proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit I) 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.

RIGHT HAND

3A. Initial ROM measurements

- All normal Abnormal or outside of normal range
 Unable to test Not indicated

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

If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a hand/fingers 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)
-

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed? Yes No

If no, provide an explanation:

If this is the unclaimed joint, is it: Damaged Undamaged

If undamaged, range of motion testing must be conducted.

LEFT HAND

3A. Initial ROM measurements

- All normal Abnormal or outside of normal range
 Unable to test Not indicated

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

If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a hand/fingers 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)
-

Can testing be performed? Yes No

If no, provide an explanation:

If this is the unclaimed joint, is it: Damaged Undamaged

If undamaged, range of motion testing must be conducted.

For the index, long, ring, and little fingers (digits II, III, IV, and V), zero degrees of flexion represents the fingers fully extended, making a straight line with the rest of the hand. The position of function of the hand is with the wrist dorsiflexed 20 to 30 degrees, the metacarpophalangeal and proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit I) abducted and rotated so that the thumb pad faces the finger pads. Only joints in these positions are considered to be in favorable position. For digits II through V, the metacarpophalangeal joint has a range of zero to 90 degrees of flexion, the proximal interphalangeal joint has a range of zero to 100 degrees of flexion, and the distal (terminal) interphalangeal joint has a range of zero to 70 or 80 degrees of flexion.

RIGHT HAND			LEFT HAND				
Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.			Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.				
Index finger	MCP	PIP	DIP	Index finger	MCP	PIP	DIP
Flexion endpoint	<hr/> 90 deg	<hr/> 100 deg	<hr/> 70 deg	Flexion endpoint	<hr/> 90 deg	<hr/> 100 deg	<hr/> 70 deg
Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	<hr/> 0 deg	Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	<hr/> 0 deg
Long finger	MCP	PIP	DIP	Long finger	MCP	PIP	DIP
Flexion endpoint	<hr/> 90 deg	<hr/> 100 deg	<hr/> 70 deg	Flexion endpoint	<hr/> 90 deg	<hr/> 100 deg	<hr/> 70 deg
Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	<hr/> 0 deg	Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	<hr/> 0 deg
Ring finger	MCP	PIP	DIP	Ring finger	MCP	PIP	DIP
Flexion endpoint	<hr/> 90 deg	<hr/> 100 deg	<hr/> 70 deg	Flexion endpoint	<hr/> 90 deg	<hr/> 100 deg	<hr/> 70 deg
Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	<hr/> 0 deg	Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	<hr/> 0 deg
Little finger	MCP	PIP	DIP	Little finger	MCP	PIP	DIP
Flexion endpoint	<hr/> 90 deg	<hr/> 100 deg	<hr/> 70 deg	Flexion endpoint	<hr/> 90 deg	<hr/> 100 deg	<hr/> 70 deg
Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	<hr/> 0 deg	Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	<hr/> 0 deg
Thumb	MCP	IP		Thumb	MCP	IP	
Flexion endpoint	<hr/> 100 deg	<hr/> 90 deg		Flexion endpoint	<hr/> 100 deg	<hr/> 90 deg	
Extension endpoint	<hr/> 0 deg	<hr/> 0 deg		Extension endpoint	<hr/> 0 deg	<hr/> 0 deg	
Is there a gap between the pad of the thumb and fingers?			Is there a gap between the pad of the thumb and fingers?				
<input type="radio"/> Yes <input type="radio"/> No	<hr/> cm		<input type="radio"/> Yes <input type="radio"/> No	<hr/> cm			
Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?			Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion?				
<input type="radio"/> Yes <input type="radio"/> No			<input type="radio"/> Yes <input type="radio"/> No				
Index Finger <hr/> cm		Long Finger <hr/> cm		Index Finger <hr/> cm	Long Finger <hr/> cm		
Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?			Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?				
<input type="radio"/> Yes <input type="radio"/> No			<input type="radio"/> Yes <input type="radio"/> No				
If yes, please explain. Include location, severity, and relationship to condition(s).			If yes, please explain. Include location, severity, and relationship to condition(s).				
<hr/> 			<hr/> 				
If noted on examination, which digit exhibited pain (select all that apply):			If noted on examination, which digit exhibited pain (select all that apply):				
<input type="checkbox"/> Index finger	<input type="checkbox"/> Long finger	<input type="checkbox"/> Thumb	<input type="checkbox"/> Index finger	<input type="checkbox"/> Long finger	<input type="checkbox"/> Thumb		
<input type="checkbox"/> Ring finger	<input type="checkbox"/> Little finger		<input type="checkbox"/> Ring finger	<input type="checkbox"/> Little finger			

If any limitation of motion or gap is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) (if different than above) in which limitation of motion or gap is specifically attributable to the factors identified and describe.

If any limitation of motion or gap is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) (if different than above) in which limitation of motion or gap is specifically attributable to the factors identified and describe.

Passive Range of Motion - Perform passive range of motion for the hand and fingers and provide the ROM values.

Index finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	
Long finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	
Ring finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	
Little finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	
Thumb	MCP	IP	
Flexion endpoint	100 deg	90 deg	
Extension endpoint	0 deg	0 deg	
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	

Passive Range of Motion - Perform passive range of motion for the hand and fingers and provide the ROM values.

Index finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	
Long finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	
Ring finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	
Little finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	
Thumb	MCP	IP	
Flexion endpoint	100 deg	90 deg	
Extension endpoint	0 deg	0 deg	
<input type="checkbox"/> Flexion same as active ROM		<input type="checkbox"/> Extension same as active ROM	

<p>Is there a gap between the pad of the thumb and fingers on passive ROM?</p> <p><input type="radio"/> Yes <input type="radio"/> No _____ cm</p> <p>Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion on passive ROM?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Index Finger _____ cm Long Finger _____ cm</p>	<p>Is there a gap between the pad of the thumb and fingers on passive ROM?</p> <p><input type="radio"/> Yes <input type="radio"/> No _____ cm</p> <p>Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion on passive ROM?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Index Finger _____ cm Long Finger _____ cm</p>
<p>Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue on passive ROM?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, please explain. Include location, severity, and relationship to condition(s). <div style="border: 1px solid black; height: 180px; width: 100%;"></div></p>	<p>Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue on passive ROM?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, please explain. Include location, severity, and relationship to condition(s). <div style="border: 1px solid black; height: 180px; width: 100%;"></div></p>
<p>If noted on examination, which digit on passive ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Index finger <input type="checkbox"/> Long finger <input type="checkbox"/> Thumb <input type="checkbox"/> Ring finger <input type="checkbox"/> Little finger</p> <p>If any limitation of motion or gap is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) (if different than above) in which limitation of motion or gap is specifically attributable to the factors identified and describe. <div style="border: 1px solid black; height: 180px; width: 100%;"></div></p>	<p>If noted on examination, which digit on passive ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Index finger <input type="checkbox"/> Long finger <input type="checkbox"/> Thumb <input type="checkbox"/> Ring finger <input type="checkbox"/> Little finger</p> <p>If any limitation of motion or gap is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) (if different than above) in which limitation of motion or gap is specifically attributable to the factors identified and describe. <div style="border: 1px solid black; height: 180px; width: 100%;"></div></p>
<p>Is there evidence of pain? <input type="radio"/> Yes <input type="radio"/> No If yes check all that apply.</p> <p><input type="checkbox"/> weight-bearing <input type="checkbox"/> nonweight-bearing <input type="checkbox"/> active motion <input type="checkbox"/> passive motion <input type="checkbox"/> on rest/non-movement <input type="checkbox"/> causes functional loss (if checked describe in the comments box below) <input type="checkbox"/> does not result in/cause functional loss</p>	<p>Is there evidence of pain? <input type="radio"/> Yes <input type="radio"/> No If yes check all that apply.</p> <p><input type="checkbox"/> weight-bearing <input type="checkbox"/> nonweight-bearing <input type="checkbox"/> active motion <input type="checkbox"/> passive motion <input type="checkbox"/> on rest/non-movement <input type="checkbox"/> causes functional loss (if checked describe in the comments box below) <input type="checkbox"/> does not result in/cause functional loss</p>
<p>Comments: <div style="border: 1px solid black; height: 180px; width: 100%;"></div></p>	<p>Comments: <div style="border: 1px solid black; height: 180px; width: 100%;"></div></p>

<p>3B. Observed repetitive use ROM - Right hand</p> <p>Is the Veteran able to perform repetitive-use testing with at least three repetitions? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If no, please explain:</p> <div style="border: 1px solid black; height: 80px; width: 450px;"></div>	<p>3B. Observed repetitive use ROM - Left hand</p> <p>Is the Veteran able to perform repetitive-use testing with at least three repetitions? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If no, please explain:</p> <div style="border: 1px solid black; height: 80px; width: 450px;"></div>																																																																																																																																
<p>Is there additional loss of function or range of motion after three repetitions?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>																																																																																																																																	
<p>If yes, please respond to the following after the completion of the three repetitions:</p>																																																																																																																																	
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Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion or gap. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees or centimeters, as applicable) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.

3C. Repeated use over time - Right hand		3C. Repeated use over time - Left hand	
Is the Veteran being examined immediately after repeated use over time?		Is the Veteran being examined immediately after repeated use over time?	
<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	
Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?		Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?	
<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	
Select factors that cause this functional loss. (Check all that apply)			
<input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness		<input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness	
<input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination <input type="checkbox"/> N/A		<input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination <input type="checkbox"/> N/A	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	
Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.			
Index finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
Long finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
Ring finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
Little finger	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg
Thumb	MCP	IP	
Flexion endpoint	100 deg	90 deg	
Extension endpoint	0 deg	0 deg	
Estimate the gap between the pad of the thumb and fingers immediately after repeated use over time.			
cm _____			
Estimate the gap between the finger and proximal transverse crease of the hand on maximal finger flexion immediately after repeated use over time.			
Index Finger	cm	Long Finger	cm
Index Finger	cm	Long Finger	cm

<p>The examiner should provide the estimated range of motion and gap based on a review of all procurable information - to include the Veteran's statement on examination, case specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.</p>	<p>The examiner should provide the estimated range of motion and gap based on a review of all procurable information - to include the Veteran's statement on examination, case specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.</p>																								
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<p>3D. Flare-ups - Right hand</p>	<p>3D. Flare-ups - Left hand</p>																								
<p>Is the Veteran being examined immediately after repeated use over time?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Is the Veteran being examined immediately after repeated use over time?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>																								
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Thumb	MCP	IP	Thumb	MCP	IP
Flexion endpoint			Flexion endpoint		
<hr/> 100 deg	<hr/> 90 deg		<hr/> 100 deg	<hr/> 90 deg	
Extension endpoint			Extension endpoint		
<hr/> 0 deg	<hr/> 0 deg		<hr/> 0 deg	<hr/> 0 deg	
Estimate the gap between the pad of the thumb and fingers immediately after repeated use over time. cm <hr/>			Estimate the gap between the pad of the thumb and fingers immediately after repeated use over time. cm <hr/>		
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Index Finger	cm	Long Finger	cm	Index Finger	cm
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Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.) <div style="border: 1px solid black; height: 100px; width: 100%;"></div>					
3E. Additional factors contributing to disability - Right hand			3E. Additional factors contributing to disability - Left hand		
In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:			In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:		
<input type="checkbox"/> None	<input type="checkbox"/> Interference with sitting	<input type="checkbox"/> None	<input type="checkbox"/> Interference with sitting		
<input type="checkbox"/> Interference with standing	<input type="checkbox"/> Swelling	<input type="checkbox"/> Interference with standing	<input type="checkbox"/> Swelling		
<input type="checkbox"/> Disturbance of locomotion	<input type="checkbox"/> Deformity	<input type="checkbox"/> Disturbance of locomotion	<input type="checkbox"/> Deformity		
<input type="checkbox"/> Less movement than normal	<input type="checkbox"/> More movement than normal	<input type="checkbox"/> Less movement than normal	<input type="checkbox"/> More movement than normal		
<input type="checkbox"/> Weakened movement	<input type="checkbox"/> Atrophy of disuse	<input type="checkbox"/> Weakened movement	<input type="checkbox"/> Atrophy of disuse		
<input type="checkbox"/> Instability of station	<input type="checkbox"/> Other, describe: <div style="border: 1px solid black; height: 50px; width: 100%;"></div>	<input type="checkbox"/> Instability of station	<input type="checkbox"/> Other, describe: <div style="border: 1px solid black; height: 50px; width: 100%;"></div>		
Please describe additional contributing factors of disability: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>			Please describe additional contributing factors of disability: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>		
SECTION IV - MUSCLE STRENGTH TESTING					
RIGHT HAND		LEFT HAND			
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:	/5	Hand grip:	/5		

4B. If the Veteran has a reduction in muscle strength, is it due to the claimed condition in the diagnosis section?	4B. If the Veteran has a reduction in muscle strength, is it due to the claimed condition in the diagnosis section?
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
If no, provide rationale:	
4C. Does the Veteran have muscle atrophy?	4C. Does the Veteran have muscle atrophy?
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4D. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
If no, provide rationale:	
4E. For any muscle atrophy due to a diagnosis listed in Section 1, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.	4E. For any muscle atrophy due to a diagnosis listed in Section 1, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.
<input type="checkbox"/> Right upper extremity (specify location of measurement):	<input type="checkbox"/> Left upper extremity (specify location of measurement):
Circumference of more normal side: _____ cm	Circumference of more normal side: _____ cm
Circumference of atrophied side: _____ cm	Circumference of atrophied side: _____ cm
SECTION V - ANKYLOSIS	
Note: Ankylosis is the immobilization of a joint due to disease, injury, or surgical procedure.	
RIGHT HAND	LEFT HAND
5A. Complete this section if the Veteran has ankylosis of any thumb or finger joints. Indicate severity of ankylosis and side affected (check all that apply):	5A. Complete this section if the Veteran has ankylosis of any thumb or finger joints. Indicate severity of ankylosis and side affected (check all that apply):
Index finger - MCP joint <input type="radio"/> No ankylosis <input type="radio"/> MCP ankylosis	Index finger - MCP joint <input type="radio"/> No ankylosis <input type="radio"/> MCP ankylosis
If ankylosed, is there rotation of a bone? <input type="radio"/> Yes <input type="radio"/> No	If ankylosed, is there rotation of a bone? <input type="radio"/> Yes <input type="radio"/> No
If ankylosed, is there angulation of a bone? <input type="radio"/> Yes <input type="radio"/> No	If ankylosed, is there angulation of a bone? <input type="radio"/> Yes <input type="radio"/> No
If ankylosed, what is the position of ankylosis? <input type="radio"/> In extension <input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis? <input type="radio"/> In extension <input type="radio"/> In full flexion
_____ Other, _____ degrees of flexion	_____ Other, _____ degrees of flexion
Index finger - PIP joint <input type="radio"/> No ankylosis <input type="radio"/> PIP ankylosis	Index finger - PIP joint <input type="radio"/> No ankylosis <input type="radio"/> PIP ankylosis
If ankylosed, is there rotation of a bone? <input type="radio"/> Yes <input type="radio"/> No	If ankylosed, is there rotation of a bone? <input type="radio"/> Yes <input type="radio"/> No
If ankylosed, is there angulation of a bone? <input type="radio"/> Yes <input type="radio"/> No	If ankylosed, is there angulation of a bone? <input type="radio"/> Yes <input type="radio"/> No
If ankylosed, what is the position of ankylosis? <input type="radio"/> In extension <input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis? <input type="radio"/> In extension <input type="radio"/> In full flexion
_____ Other, _____ degrees of flexion	_____ Other, _____ degrees of flexion

Long finger - MCP joint	<input type="radio"/> No ankylosis	<input type="radio"/> MCP ankylosis	Long finger - MCP joint	<input type="radio"/> No ankylosis	<input type="radio"/> MCP ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion
Long finger - PIP joint	<input type="radio"/> No ankylosis	<input type="radio"/> PIP ankylosis	Long finger - PIP joint	<input type="radio"/> No ankylosis	<input type="radio"/> PIP ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion
Ring finger - MCP joint	<input type="radio"/> No ankylosis	<input type="radio"/> MCP ankylosis	Ring finger - MCP joint	<input type="radio"/> No ankylosis	<input type="radio"/> MCP ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion
Ring finger - PIP joint	<input type="radio"/> No ankylosis	<input type="radio"/> PIP ankylosis	Ring finger - PIP joint	<input type="radio"/> No ankylosis	<input type="radio"/> PIP ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion
Little finger - MCP joint	<input type="radio"/> No ankylosis	<input type="radio"/> MCP ankylosis	Little finger - MCP joint	<input type="radio"/> No ankylosis	<input type="radio"/> MCP ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion
Little finger - PIP joint	<input type="radio"/> No ankylosis	<input type="radio"/> PIP ankylosis	Little finger - PIP joint	<input type="radio"/> No ankylosis	<input type="radio"/> PIP ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion
Thumb - CMC joint	<input type="radio"/> No ankylosis	<input type="radio"/> CMC ankylosis	Thumb - CMC joint	<input type="radio"/> No ankylosis	<input type="radio"/> CMC ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion

Thumb - MCP joint	<input type="radio"/> No ankylosis	<input type="radio"/> MCP ankylosis	Thumb - MCP joint	<input type="radio"/> No ankylosis	<input type="radio"/> MCP ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion
Thumb - IP joint	<input type="radio"/> No ankylosis	<input type="radio"/> IP ankylosis	Thumb - IP joint	<input type="radio"/> No ankylosis	<input type="radio"/> IP ankylosis
If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there rotation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No	If ankylosed, is there angulation of a bone?	<input type="radio"/> Yes	<input type="radio"/> No
If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion	If ankylosed, what is the position of ankylosis?	<input type="radio"/> In extension	<input type="radio"/> In full flexion
	<input type="radio"/> Other, _____	degrees of flexion		<input type="radio"/> Other, _____	degrees of flexion
5B. Does the ankylosis result in limitation of motion of other digits or interference with overall function of the hand?			5B. Does the ankylosis result in limitation of motion of other digits or interference with overall function of the hand?		
<input type="radio"/> Yes <input type="radio"/> No			<input type="radio"/> Yes <input type="radio"/> No		
If no, provide rationale:			If no, provide rationale:		

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 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 VII - ASSISTIVE DEVICES

7A. Does the Veteran use any assistive devices? Yes No

If yes, identify the assistive devices used (check all that apply and indicate frequency):

Brace Frequency of use: Occasional Regular Constant

Other, describe: _____ Frequency of use: Occasional Regular Constant

7B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

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 prosthesis. 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.

8A. Due to the Veteran's hand, finger, or thumb condition(s), 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.)?

Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran No

If yes, indicate extremities for which this applies: Right upper Left upper

8B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

SECTION IX - DIAGNOSTIC TESTING

Note: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or post-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 clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination?

Yes No

9B. If yes, is degenerative or post-traumatic arthritis documented? Yes No

Indicate side: Right Left Both

9C. Is degenerative or post-traumatic arthritis documented in multiple joints of the same hand, including thumb and fingers? Yes No

If yes, indicate side: Right Left Both

9D. If yes (to 9B and/or 9C), provide type of test or procedure, date, and results (brief summary):

9E. Are there any other clinically relevant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

Yes No

If yes, provide type of test or procedure, date, and results (brief summary):

9F. 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.

10A. 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 XI - REMARKS

11A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

12A. Examiner's signature:	12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):
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12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	12D. Date Signed:
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12E. Examiner's phone/fax numbers:	12F. National Provider Identifier (NPI) number:	12G. Medical license number and state:
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12H. Examiner's address:
