Department of Veterans Affairs

PARKINSON'S DISEASE 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.

SECTION I - DIAGNOSIS

1A. Does the Veteran now have or has he or she ever been diagnosed with Parkinson's disease or parkinsonism?

◯ Yes ◯ No

If yes, indicate which condition:

◯ Parkinson's disease ◯ Parkinsonism 1B. ICD Code(s): 1C. Date of Diagnosis:

SECTION II - DOMINANT HAND

2. Dominant hand:

◯ Right ◯ Left ◯ Ambidextrous

SECTION III - MOTOR MANIFESTATIONS

3. Motor manifestations due to Parkinson's / parkinsonism or its treatment (check all that apply)

Motor Manifestations

3A. Stooped posture

◯ None ◯ Mild ◯ Moderate ◯ Severe

3B. Balance impairment

◯ None ◯ Mild ◯ Moderate ◯ Severe

3C. Bradykinesia or slowed motion (difficulty initiating movement, "freezing," short shuffling steps)

◯ None ◯ Mild ◯ Moderate ◯ Severe

3D. Loss of automatic movements (such as blinking, leading to fixed gaze, typical Parkinson's facies)

◯ None ◯ Mild ◯ Moderate ◯ Severe

3E. Speech changes (monotone, slurring words, soft or rapid speech)

◯ None ◯ Mild ◯ Moderate ◯ Severe

3F. Tremor (characteristic hand shaking, "pill-rolling")

◯ Yes ◯ No

Extremities affected:

Right upper	◯ Not affected	◯ Mild	◯ Moderate	◯ Severe
Left upper	◯ Not affected	◯ Mild	◯ Moderate	◯ Severe
Right lower	◯ Not affected	◯ Mild	◯ Moderate	◯ Severe
Left lower	◯ Not affected	◯ Mild	◯ Moderate	◯ Severe

3G. Muscle rigidity and stiffness

◯ Yes ◯ No

Extremities affected:

Right upper	◯ Not affected	◯ Mild	◯ Moderate	◯ Severe
Left upper	◯ Not affected	◯ Mild	◯ Moderate	◯ Severe
Right lower	◯ Not affected	◯ Mild	◯ Moderate	◯ Severe
Left lower	◯ Not affected	◯ Mild	◯ Moderate	◯ Severe

SECTION IV - MENTAL MANIFESTATIONS

4. Mental manifestations due to Parkinson's / parkinsonism or its treatment (Check all that apply)

(If there are mental manifestations due to Parkinson's/parkinsonism, ALSO complete the Mental Disorders Disability Benefits Questionnaire (schedule with appropriate provider))

Mental Manifestations

4A. Depression

◯ None ◯ Mild ◯ Moderate ◯ Severe

4B. Cognitive impairment or dementia

◯ None ◯ Mild ◯ Moderate ◯ Severe

SECTION V - ADDITIONAL MANIFESTATIONS/COMPLICATIONS

5. Additional manifestations/complications due to Parkinson's / parkinsonism or its treatment

Additional Manifestations/Complications

5A. Loss of sense of smell

◯ None ◯ Partial ◯ Complete

5B. Sleep disturbance (insomnia or daytime "sleep attacks")

◯ None ◯ Mild ◯ Moderate ◯ Severe

5C. Difficulty chewing/swallowing

◯ None ◯ Mild ◯ Moderate ◯ Severe

5D. Urinary problems (Incontinence or urinary retention)

Indicate "None" or, if absorbent material required due to incontinence, specify pads/day.

◯ None ◯ 0 ◯ 1 ◯ 2-4 ◯ >4

Use of an appliance required?

◯ Yes ◯ No

5E. Constipation (due to slowing of GI tract or secondary to Parkinson's medications)

◯ None ◯ Mild ◯ Moderate ◯ Severe

5F. Sexual dysfunction

◯ None ◯ Mild ◯ Moderate ◯ Severe (precludes intercourse, including erectile dysfunction or Female Sexual Arousal Disorder (FSAD))

Note: Female Sexual Arousal Disorder (FSAD) refers to the continual or recurrent physical inability of a woman to accomplish or maintain an ample lubrication-swelling reaction during sexual intercourse. Decreased blood flow to the genital area is believed to contribute to FSAD similar to the role of vascular disease in male erectile dysfunction. Other causes may include nerve and/or tissue damage

5G. Other manifestations/complications

◯ None ◯ Mild ◯ Moderate ◯ Severe

(Specify)

SECTION VI - FINANCIAL RESPONSIBILITY

6. Financial responsibility - In your judgment, is the Veteran able to manage his/her benefit payments in his/her own best interest, or able to direct someone else to do so?

◯ Yes ◯ No

SECTION VII - FUNCTIONAL IMPACT

7. Does the Veteran's Parkinson's / parkinsonism impact his or her ability to work?

◯ Yes ◯ No

(If "Yes," describe impact and provide one or more examples)

SECTION VIII - REMARKS

8. Additional remarks (if any)

SECTION IX - 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.

9A. Examiner's signature:	9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	9D. Date Signed:

9E. Examiner's phone/fax numbers:	9F. National Provider Identifier (NPI) number:	9G. Medical license number and state:

9H. Examiner's address: