Department of Veterans Affairs

MULTIPLE SCLEROSIS (MS) 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 Multiple Sclerosis (MS)?

◯ Yes ◯ No

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

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 MS, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's MS (brief summary):

2B. Dominant hand

◯ Right ◯ Left ◯ Ambidextrous

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO MS

3A. Does the Veteran report any muscle weakness in the upper and/or lower extremities attributable to MS?

◯ Yes ◯ No

(If "Yes," document under strength testing in neurologic exam section)

3B. Does the Veteran have any pharynx and/or larynx and/or swallowing conditions attributable to MS?

◯ 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

☐ Dysphagia (difficulty swallowing)

☐ Requiring daily medication to control dysphagia

☐ Documented history of esophageal stricture(s) attributable to MS (see Note 1) (If checked indicate if recurrent or refractory)

Note 1: Findings must be documented by barium swallow, computerized tomography (CT), or esophagogastroduodenoscopy (EGD). (Indicate date of study in the Remarks section.)

Note 2: Recurrent esophageal stricture is defined as the inability to maintain target esophageal diameter beyond 4 weeks after the target diameter has been achieved. Refractory esophageal stricture is defined as the inability to achieve target esophageal diameter despite receiving no fewer than 5 dilatation sessions performed at 2-week intervals.

Has the esophageal stricture(s) been recurrent or refractory? (see Note 2)

◯ Yes ◯ No

☐ Without daily symptoms

☐ Without requirement for daily medications

☐ Requiring dilatation (if checked indicate frequency and list most recent dates):

◯ No more than 2 times a year ◯ 3 or more times a year

Was there dilatation utilizing steroids at least 1 time per year?

◯ Yes ◯ No

Date of dilatation: _____ Date of dilatation: _____ Date of dilatation: _____

☐ Requiring esophageal stent placement

☐ Treatment with surgical correction

☐ Aspiration

☐ Undernutrition (see Note 3)

☐ Substantial weight loss (see Note 4)

☐ Treatment with a percutaneous esophago-gastrointestinal tube (PEG tube)

☐ Other, symptom(s) specify:

_____

Note 3: "Undernutrition" means a deficiency resulting from insufficient intake of one or multiple essential nutrients, or the inability of the body to absorb, utilize, or retain such nutrients. Undernutrition is characterized by failure of the body to maintain normal organ functions and healthy tissues. Signs and symptoms may include: loss of subcutaneous tissue, edema, peripheral neuropathy, muscle wasting, weakness, abdominal distention, ascites, and Body Mass Index below normal range.

Note 4: "Substantial weight loss" means involuntary loss greater than 20 percent of an individual's baseline weight sustained for three months with diminished quality of self-care or work tasks. "Baseline weight" means the clinically documented average weight for the two-year period preceding the onset of illness or, if relevant, the weight recorded at the Veteran's most recent discharge physical. If neither of these weights is available or currently relevant, then use ideal body weight as determined by either the Hamwi formula or Body Mass Index tables, whichever is most favorable to the Veteran.

3C. Does the Veteran report any respiratory conditions attributable to MS?

◯ Yes ◯ No

(If "Yes," provide PFT results under "Diagnostic Testing" Section)

3D. Does the Veteran report sleep distrubances attributable to MS?

◯ Yes ◯ No

(If "Yes," check all that apply):

☐ Insomnia

☐ Hypersomnolence and/or daytime "sleep attacks "

☐ Persistent daytime hypersomnolence

☐ Sleep apnea requiring the use of breathing assistance device such as continuous airway pressure (CPAP) machine, etc.

☐ Sleep apnea causing chronic respiratory failure with carbon dioxide retention or cor pulmonale

☐ Sleep apnea requiring tracheostomy

Note: Complete or partial loss of sphincter control refers to the inability to retain or expel stool at an appropriate time and place.

3E. Does the Veteran have impairment of sphincter control attributable to MS?

◯ Yes ◯ No If "Yes," indicate severity:

◯ History of loss of sphincter control, currently asymptomatic

◯ Complete loss of sphincter control

◯ Partial loss of sphincter control

3F. Does the Veteran report bowel incontinence to solids and/or liquids attributable to MS?

◯ Yes ◯ No If "Yes," indicate frequency:

◯ Less than once every six months, which requires wearing a pad at least once every six months

◯ At least once every six months, which requires wearing a pad at least once every six months

◯ Two or more times per month, which requires wearing a pad two or more times per month

◯ Two or more times per week, which requires wearing a pad two or more times per week

◯ Two or more times per day, which requires changing a pad two or more times per day

3G. Does the Veteran have a physician-prescribed bowel program?

◯ Yes ◯ No If "Yes," indicate responsiveness:

◯ Fully responsive

◯ Partially responsive

◯ Not responsive

Indicate the bowel program requirements (Check all that apply)

☐ Special diet

☐ Medication If checked, are there prescribed medication(s) beyond laxative use?

◯ Yes ◯ No

☐ Digital stimulation

☐ Surgery

If checked, provide the date of surgery or anticipated date of surgery:

☐ Other, please describe:

3H. Does the Veteran report gastrointestinal symptoms attributable to MS?

◯ Yes ◯ No If "Yes," check all that apply:

☐ Change in stool frequency ☐ Change in stool form ☐ Altered stool passage (straining and/or urgency) ☐ Mucorrhea

☐ Abdominal bloating ☐ Subjective distention ☐ Constipation

☐ Other (specify): _____

☐ Abdominal pain related to defecation (if checked, indicate frequency during the previous 3 months)

◯ None ◯ At least once ◯ At least 3 days per month ◯ At least 1 day per week

3I. Does the Veteran report voiding dysfunction causing urine leakage attributable to MS?

◯ 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

3J. Does the Veteran report voiding dysfunction causing signs and/or symptoms of urinary frequency attributable to MS?

◯ Yes ◯ No

(If "Yes," check all that apply)

◯ Daytime voiding interval greater than 3 hours ◯ Nighttime awakening to void less than 2 times

◯ Daytime voiding interval between 2 and 3 hours ◯ Nighttime awakening to void 2 times

◯ Daytime voiding interval between 1 and 2 hours ◯ Nighttime awakening to void 3 to 4 times

◯ Daytime voiding interval less than 1 hour ◯ Nighttime awakening to void 5 or more times

3K. Does the Veteran have voiding dysfunction causing findings, or report signs and/or symptoms of obstructed voiding attributable to MS?

◯ 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

3L. Does the Veteran have voiding dysfunction requiring the use of an appliance attributable to MS?

◯ Yes ◯ No (If "Yes," describe appliance):

3M. Does the Veteran have a history of recurrent symptomatic urinary tract infections attributable to MS?

◯ Yes ◯ No

(If "Yes," check all treatments that apply)

☐ No treatment

☐ Suppressive drug therapy

◯ Lasting 6 months or longer ◯ For less than 6 months

☐ Hospitalization

(If checked, indicate frequency of hospitalization) ◯ 1 or 2 per year ◯ More than 2 per year

☐ Drainage by stent or nephrostomy tube

☐ Continuous intensive management required

☐ Other management/treatment not listed above (Description of management/treatment including dates of treatment):

For all options checked above, list medications/management/treatments used for urinary tract infection and indicate dates for courses of treatment over the past 12 months:

3N. Does the Veteran have or report any visual disturbances attributable to MS?

◯ Yes ◯ No

(If "Yes," check all that apply, also complete the Eye Questionnaire (schedule with appropriate examiner)):

☐ Diplopia

☐ Blurring of vision

☐ Internuclear ophthalmoplegia

☐ Decreased visual acuity (If checked, specify): ◯ unilateral ◯ bilateral

☐ Visual scotoma (If checked, specify): ◯ unilateral ◯ bilateral

☐ Nystagmus

☐ Optic neuritis

☐ Other (describe):

3O. Does the Veteran report erectile dysfunction or female sexual arousal disorder (FSAD) attributable to MS?

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.

◯ Yes ◯ No

SECTION IV - NEUROLOGIC EXAM

4A. 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):

4B. Strength - Rate strength according to the following scale:

0/5 No muscle movement
1/5 Visible muscle movement, but no joint movement
2/5 No movement against gravity
3/5 No movement against resistance
4/5 Less than normal strength
5/5 Normal strength

Shoulder Extension:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Shoulder Flexion:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Elbow Flexion:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Elbow Extension:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Wrist Flexion:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Wrist Extension:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Grip:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Pinch (thumb to index finger):	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Hip Extension:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Hip Flexion:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Knee Extension:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Ankle Plantar Flexion:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
Ankle Dorsiflexion:	Right:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5
	Left:	◯ 5/5	◯ 4/5	◯ 3/5	◯ 2/5	◯ 1/5	◯ 0/5

If there are other weaknesses, please specify using the above format:

4C. 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

Biceps:	Right:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
	Left:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
Triceps:	Right:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
	Left:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
Brachioradialis:	Right:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
	Left:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
Knee:	Right:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
	Left:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
Ankle:	Right:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
	Left:	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+

4D. Sensation testing results:

Shoulder area (C5):	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent
Inner/outer forearm (C6/T1):	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent
Hand/fingers (C6-8):	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent
Thorax:				
Anterior:	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent
Posterior:	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent
Trunk:				
Anterior:	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent
Posterior:	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent
Thigh/knee (L3/4):	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent

Lower leg/ankle (L4/L5/S1):	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent
Foot/toes (L5):	Right:	◯ Normal	◯ Decreased	◯ Absent
	Left:	◯ Normal	◯ Decreased	◯ Absent

4E. Does the Veteran have muscle atrophy attributable to MS?

◯ 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).

4F. Summary of muscle weakness in the upper and/or lower extremities attributable to MS (check all that apply):

Right upper extremity muscle weakness:

◯ None ◯ Mild ◯ Moderate

◯ Severe ◯ Complete (no remaining function) ☐ With atrophy

Left upper extremity muscle weakness:

◯ None ◯ Mild ◯ Moderate

◯ Severe ◯ Complete (no remaining function) ☐ With atrophy

Right lower extremity muscle weakness:

◯ None ◯ Mild ◯ Moderate

◯ Severe ◯ Complete (no remaining function) ☐ With atrophy

Left lower extremity muscle weakness:

◯ None ◯ Mild ◯ Moderate

◯ Severe ◯ Complete (no remaining function) ☐ With atrophy

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, condititions, signs and/or symptoms related to any conditions listed in the diagnosis section?

◯ Yes ◯ No

(If "Yes," describe in a 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 above?

◯ Yes ◯ No If "Yes," also complete the appropriate dermatological questionnaire.

5C. Comments, if any:

SECTION VI - MENTAL HEALTH MANIFESTATIONS DUE TO MULTIPLE SCLEROSIS OR ITS TREATMENT

6A. Does the Veteran have depression, cognitive impairment or dementia, or any other mental disorder attributable to MS and/or its treatment?

◯ Yes ◯ No

(If "Yes," also complete Mental Disorders Disability Benefits Questionnaire and schedule with appropriate provider)

SECTION VII - HOUSEBOUND

7A. Due to MS, 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. If yes, 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)

Provide conditions and describe how each condition contributes to the Veteran being housebound:

Condition # 1 -	Description -
Condition # 2 -	Description -
Condition # 3 -	Description -

7C. If the Veteran has additional conditions contributing to causing the Veteran to be housebound, list using above format:

SECTION VIII - AID AND ATTENDANCE

Note: Responses in this section should only relate to impairments or limitations that are due to MS.

8A. Is the Veteran able to dress or undress without assistance?

◯ 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

8C. Is the Veteran able to prepare meals without assistance?

◯ Yes ◯ No

8D. Is the Veteran able to attend to the wants of nature (toileting) without assitance?

◯ Yes ◯ No

8E. Is the Veteran able to bathe him or herself without assistance?

◯ Yes ◯ No

8F. Is the Veteran able to keep him or herself ordinarily clean and presentable without assistance?

◯ Yes ◯ No

8G. Is the Veteran able to take prescription medications in a timely manner and with accurate dosage without assistance?

◯ Yes ◯ No

8H. Does the Veteran need frequent assistance for adjustment of any special prosthetic or orthopedic appliance(s)?

◯ Yes ◯ No (If "Yes," describe):

NOTE: For VA purposes, "bedridden" will be that condition which actually requires that the claimant remain in bed. The fact that the 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.

8I. Is the Veteran bedridden?

◯ Yes ◯ No

8J. Is the Veteran legally blind?

◯ Yes ◯ No

Provide best corrected vision, if known: Left Eye: _____ Right Eye: _____

8K. 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 enviroment?

◯ Yes ◯ No

8L. List any condition(s), in addition to the veteran's MS, that causes any of the above limitations:

SECTION IX - NEED FOR HIGHER LEVEL (i.e., more skilled) AID & ATTENDANCE (A&A)

9A. 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)

☐ Wheelchair	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Brace(s)	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Crutch(es)	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Cane(s)	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Walker	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Other: _____	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant

10B. 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

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.

11A. Due to the MS 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

(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 in a brief summary):

SECTION XII - FINANCIAL RESPONSIBILITY

12A. 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 reason):

SECTION XIII - DIAGNOSTIC TESTING

NOTE: If the results of MRI, other imaging studies or other diagnostic tests are in the medical record and reflect the Veteran's current condition, repeat testing is not required. 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 Multiple Sclerosis.

13A. Have imaging studies been performed?

◯ Yes ◯ No

(If "Yes," provide most recent results, if available):

13B. Have PFTs been performed?

◯ Yes ◯ No

(If "Yes," provide most recent results, if available):

FEV1: _____ % predicted Date of test: _____

FEV1/FVC: _____ % Date of test: _____

FVC: _____ % predicted Date of test: _____

13C. If PFTs have been performed, is the flow-volume loop compatible with upper airway obstruction?

◯ Yes ◯ No

(If "Yes," provide type of test or procedure, date and results, in a brief summary):

13D. Are there any other significant diagnostic test findings and/or results?

◯ Yes ◯ No

(If "Yes," provide type of test or procedure, date and results, in a brief summary):

SECTION XIV - FUNCTIONAL IMPACT

14A. Does the Veteran's MS impact his or her ability to work?

◯ Yes ◯ No (If "Yes," describe impact of the Veteran's MS, providing one or more examples):

SECTION XV - REMARKS

15A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XVI - 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.

16A. Examiner's signature:	16B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

16C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	16D. Date Signed:

16E. Examiner's phone/fax numbers:	16F. National Provider Identifier (NPI) number:	16G. Medical license number and state:

16H. Examiner's address: