PLEASE SEE THE LAST PAGE FOR HELPFUL HINTS FROM THE SEVEN STEPS TEAM:

PERFORMANCE WORK STATEMENT (PWS)

A.1 INTRODUCTION

A.1.1 The title of this PWS is the Contract Medical Disability Examination Project. Public Law 104-275 authorized the Department of Veterans Affairs (VA) to conduct a limited pilot program to contract for medical examinations from non-VA medical sources at up to 10 VA regional offices (VARO). The pilot commenced on May 1, 1998 and will terminate with the current contractor on April 30, 2003. An expiration date for this authority was not specified; therefore, the VA is planning to select a contractor for another five-year period to begin on May 1, 2003, through April 30, 2008. Performance will constantly be measured. The goal of this and other concurrent VA initiatives is to quantitatively improve the overall level of service provided the nation's veteran population. The volume of disability examinations is approximately 50,000 to 60,000 per year for the 10 regional offices and 22 Benefits Delivery at Discharge (BDD) sites.

A.1.2 Participating VAROs currently include: Greater Atlanta, including North and Central Georgia (including BDD sites Ft. Benning, Ft. Gordon, Ft. Stewart); Boston; Houston and San Antonio, Texas (including Brooks AFB, Corpus Christi, Ft. Sam Houston, Lackland AFB, Randolph AFB, and Sheppard AFB); Greater Los Angeles; Muskogee (to include Altus AFB, Ft. Sill, Sheppard AFB, Tinker AFB and Vance AFB); Roanoke (to include Portsmouth); Salt Lake City (to include Hill AFB); San Diego (Riverside county and Camp Pendleton); Seattle and surrounding areas (including Bremerton Naval Station), and the Spokane area; and Winston-Salem (Coastal and Mountain areas of North Carolina and Camp Lejeune, Ft. Bragg, Pope AFB, and Seymour-Johnson AFB). A specific portion of the examinations within the jurisdiction of these VAROs will be dedicated to the contractor. These locations are subject to change as required by the VA in which 60-90 days ramp-up time will be provided to the contractor to hire and train additional personnel.

B.1 BACKGROUND

B.1.1 The VA annually administers, through the Veterans Benefits Administration (VBA), a compensation and pension (C&P) program valued at approximately $22 billion in annual benefit payments. Benefits are paid to veterans, their dependents, and their survivors. Entitlement determinations for disability compensation (based on disabilities deemed to be service related) and disability pension (needs based entitlement for wartime veterans with non-service related disabilities) are made by disability panels located at 57 VAROs. Generally, jurisdiction for compensation and

original pension payments corresponds with state boundaries, but with jurisdiction divided between three VAROs for California and two VAROs each for New York, Pennsylvania, and Texas. A VARO located in San Juan has jurisdiction for veterans residing in Puerto Rico and the Virgin Islands. A VARO located in Manila has jurisdiction over Philippine cases.

B.1.2 Annually, the VA receives over 120,000 original disability compensation claims, over 390,000 reopened compensation claims, and over 30,000 pension claims. Examinations for disability determination purposes are conducted at local VA medical centers (VAMC) based upon VARO requests. More than 300,000 are performed annually. Examinations are required to support original disability determinations, claims for increased benefits, appellate reviews, and for review of disabilities considered likely to improve.

C.1 SCOPE

C.1.1 Contractor shall have the capability to receive an encrypted text file (format predetermined by the VA), and process a quantity of 200-400 VA examination requests on a daily basis. Daily workload will fluctuate depending on the current VA workload trends. The current daily average is 237.

C.1.2 Contractor shall schedule examinations. The contractor shall notify the veteran at least five days prior to the scheduled appointment.

C.1.2.1 Contractor shall provide the VARO a copy of the examination notification letter and forward a copy to any documented Power of Attorney (POA)/Veteran Service Organization representative.

C.1.3 Contractor shall schedule examinations as close to the veteran's home of record as feasible; but no further than (30) miles for non-specialist examination and one hundred (100) miles for specialist examinations. The VA will give consideration to allowing for greater distances for remote geographical areas where examiners and specialists may be scarce due to smaller populations; however, every effort shall be made by the contractor to find a physician as close to the veteran's home as possible.

C.1.4 Contractor shall provide physicians a copy of the veteran's medical records prior to the examination in a secure manner. The VA claims file may not be sent to the examiner. A claims file will not be sent to the contractor for every examination request.

C.1.4.1 Contractor shall be responsible for returning the veterans claims folders assembled in the same order in which they were received no later than five workdays after completion of the requested examination. The contractor shall ensure that the records are returned via a secure, traceable, mailing method.

C.1.5 Contractor shall provide state licensed, board certified physicians to conduct examinations and appropriate facilities to conduct required laboratory testing, for the following areas such as: musculoskeletal; organs of sense, infectious, immune, and nutritional deficiencies; respiratory; cardiovascular; digestive; genitourinary; gynecological and breast; hemic and lymphatic; skin; endocrine; neurologic; mental disorders; dental and oral examinations. Time begins on the date the contractor receives the examination request and ends on the date the report is delivered to the VA.

Examinations for the following categories will remain within the VA system except for special exception cases that will be agreed upon in advance by VA and the contractor: Original Gulf War Environmental Claims for undiagnosed illnesses; U.S. Court of Veterans Appeals cases; examinations for Aid and Attendance/Housebound benefits; examinations requiring hospitalization or surgical evaluation, such as sleep apnea or endometriosis needing laparoscopy; former Prisoners of War; 38 USC 1151 initial determinations; veterans residing in VA domiciliaries/nursing homes; and incarcerated veterans. In addition, no requests for review of records in the determination of Death Indemnity Compensation (DIC) will be sent to the contractor.

C.1.5.1 Contractor shall ensure that examinations for audiology are conducted by State licensed audiologists who will use the Maryland CNC hearing test.

C.1.6 Contractor shall ensure that physicians are compliant with OSHA and the American Disabilities Act.

C.1.7 Contractor shall conduct examinations in accordance with Exhibit 2. Contractor shall examine all conditions listed in the examination request and address all factors in the examination worksheets. Changes made to the examination worksheets by VA will be provided to the contractor within seven calendar days and will not revise the price schedule.

C.1.8 Contractor shall monitor physicians' offices to ensure that veterans are seen within one hour of the scheduled appointment time. Contractor shall investigate tardiness and habitual delays with physicians and take corrective action to eliminate or minimize future delays.

C.1.9 Contractor shall document in the examination report that all gyynecological, rectal/anal and breast examinations are performed by a physician in the presence of a female assistant for female patients.

C.1.10 Contractor shall conduct only those tests specifically required in the worksheets. Contractor shall not conduct invasive testing without prior approval from the VARO requesting the examination.

C.1.11 Contractor shall forward to VA completed examination reports within 38 days of receipt.

C.1.12 Contractor's examination reports shall be no more than 4-6% insufficient which will be measured quarterly by random sample.

C.1.13 Contractor shall return insufficient examination reports to VA within 14 calendar days without additional charge. Insufficient examination reports are those that do not meet the examination worksheets requirements (i.e., no diagnosis, no testing performed, etc.) The only exception will be for charges incurred due to additional tests authorized by VA.

C.1.14 Contractor shall pay veterans a travel reimbursement of eleven (11) cents a mile, unless the examination is conducted in the same city in which the individual examined resides. The contractor shall pay travel expense reimbursements directly to the individuals at the time they report for the examination. Contractor shall reimburse veterans for tolls (bridges, etc.). Contractor shall reimburse severely disabled veterans for taxi fares when there is no other means of transportation to the examination site.

C.1.15 Contractor shall have the capability to send and receive e-mail and provide those addresses to the VAROs.

C.1.16 The contractor shall provide VA access to its Management Information System for real-time status information such as veteran examination requests.

C.1.17 Contractor shall provide toll-free access for veterans to call with questions regarding their scheduled appointments. The contractor shall provide access to their administrative office from 8 AM to 7 PM Eastern time.

C.1.18 Contractor shall resolve any erroneous bills received by veterans.

C.1.19 Contractor shall appoint a program manager to be responsible for effective liaison with VARO examination coordinators and the VA Central Office (VACO) program manager.

C.1.20 Contractor shall maintain a database (.dbf format compatible) of examination requests and provide a monthly status report to each VARO and VACO.

C.1.21 Contractor shall provide the VA with an electronic version of their monthly invoices to the VA project manager for payment processing containing the following information: a list of services performed (an invoice), including examination category(s), tests completed with related Current Procedural Terminology (CPT) codes, descriptive titles and associated fees.

C.1.22 Contractor shall develop with the VA COTR, and bear the cost of, a customer survey card/questionnaire with no more than five questions and an instruction letter to be issued to every veteran at the time he/she checks in with the receptionist at the

physician's office (prior to examination). Contractor shall bear the cost of postage and provide the independent contractor's return address so that the independent contractor can tally the results on an ongoing basis. Development of the customer survey card shall take place after contract award and the first five months of the contract period shall be considered a test period where no incentives/deductions are applicable.

D.1 APPLICABLE DIRECTIVES

C&P examination worksheets are attached in Exhibit 2.

E.1 PERFORMANCE REQUIREMENTS

See Performance Requirement Summary, Exhibit No. 1.

F.1 DELIVERABLES

F.1.1 Performance Period: The contractor shall complete the work required under this SOW as specified, unless otherwise directed by the Contracting Officer (CO). If the contractor proposes an earlier completion date, and the Government accepts the contractor’s proposal, the contractor’s proposed completion date shall prevail.

F.1.2 Type of Contract: This is a firm-fixed-price, performance-based contract based on a predetermined schedule of fees. Positive and negative incentives will be applied for performance on a quarterly basis for timeliness and quality. All other performance metrics will be measured either semi-annually, or annually.

G.1. CONTRACT AWARD MEETING

The contractor shall not commence performance on the tasks in this SOW until the CO has conducted a kick off meeting or has advised the contractor that a kick off meeting is waived.

H.1. GENERAL REQUIREMENTS

H.1.1 For every task, the contractor shall identify in writing all necessary subtasks (if any), associated costs by task, together with associated submilestone dates. The contractor's subtask structure shall be reflected in the technical proposal and detailed project management plan (PMP).

H.1.2 All written deliverables will be phrased in layperson language. Statistical and other technical terminology will not be used without providing a glossary of terms.

I.1 PERSONNEL

I.1.1 The contractor shall ensure that medical examinations are conducted by a graduate of an accredited medical school, who is licensed to practice in the State where he/she conducts examinations. Excluded from participation are individuals who are excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally assisted program; whose license to provide health care services is currently revoked or suspended by a State licensing authority pursuant to adequate due process procedures for reasons bearing on professional competence, professional conduct, or financial integrity; or who, until a final determination is made, has surrendered such a license while formal disciplinary proceedings involving professional conduct are pending. Examiners' licenses must be clear and unrestricted while performing examinations under this contract. The contractor shall ensure that examiners have current medical liability insurance coverage. For States that maintain lower levels of malpractice insurance requirements for examiners/dentists, the VA will accept those State levels for the purposes of this contract. The contractor shall maintain documentation of their credentialling review on file and make that information available to the VA for review on demand. The contractor shall check the status of the examiners on a semi-annual basis to ensure that licensing has not been revoked or disciplinary proceedings involving professional conduct are pending.

J.1 TRAINING

J.1.1 The contractor, in consultation with the VA, shall prepare and implement a training program for all examiners to provide a basic overview of VA programs, available sources of veteran assistance, and an understanding of the core claims adjudication process (what the veteran may expect after the examination, who makes the decision, and whom to contact for more information). Information concerning referral to the VA's health care system shall also be provided.

J.1.2 The contractor shall provide orientation and instructions to the examiners for conducting examinations for VA purposes based on the requirements provided in the C&P examination worksheets. In addition, the contractor shall provide training to the examiners to:

- explain the differences between a VA disability examination protocol versus the examination protocol for treatment purposes
- ensure an appropriate attitude towards veterans and their unique circumstances
- ensure that examiners understand the VA's principle of reasonable doubt ("as least as likely as not") in the application of disabilities
- explain the concept of presumptive diagnoses in view of unique circumstances of military service
- ensure that examiners understand how to assess and document pain.

The contractor shall provide the training materials and the C&P examination worksheets to each examiner either in paper or electronic format.

J.1.3 The contractor, in consultation with the VA, shall prepare and implement a training program for all support staff personnel who will have routine contact with veterans, to provide a basic overview of the VA programs, available sources of veteran assistance and an understanding of the core claims adjudication process (what the veteran may expect after the examination, who makes the decision, and who to contact for more information). Information concerning referral to the VA's health care system will also be provided.

K.1 QUALITY CONTROL

K.1.1 The contractor shall demonstrate a quality assurance program to ensure that examination reports comply with the VA requirements before submission to the VA. The contractor shall take corrective action when examination deficiencies are identified and return any corrective/additional information to VA within 14 business days.

L1. PRIVACY ACT INFORMATION

L.1.1 The contractor's staff will have access to sensitive veterans' records. The contractor shall prevent the unauthorized release of information obtained by employees in the performance of work required by this contract. The contractor shall ensure that employees are aware of and receive training, as necessary, on all regulations and laws such as the Privacy Act that restricts the release of information. Veterans claims files and all examination reports and testing results are the property of the VA and the information contained therein is protected under the Privacy Act. All veteran claims folders forwarded for copying/scanning must be maintained in locked files while under the care of the contractor.

M.1 PHASE-IN PERFORMANCE AND PERIODS OF PERFORMANCE

M.1.1 Phase-in Performance consists of all the preparation activities, including but not limited to making capital expenditures, ensuring a qualified workforce in place, providing appropriate training, and implementing the information technology support necessary to fully perform the requirements contained in this statement of work and contract on May 1, 2003. The contractor shall begin performance of all requirements under this contract and conduct the Contract Medical Disability Examinations at all locations on May 1, 2003. The period of performance for the Phase-in Period will begin at contract award and last for approximately four months (based on awarding the contract at the end of December 2002 and start up on May 1 2003. The Base Period will be a full year and begin on May 1, 2003 and end on April 30, 2004. The First, Second, Third and Fourth Options periods, as well as any additional options years awarded, will be one year long. The incentives will not be applied during the phase-in period. In addition, the phase-in performance shall be applied to new jurisdictions that the contractor agrees to assume upon the request of the VA. Upon assuming new jurisdictions, the contractor shall be provided a phase-in period not to exceed 6 months to adjust to the additional

workload. This is to provide the contractor adequate time to retain and train any new employees or examiners necessary to complete the additional work.

Exhibit No. 1
Performance Requirements Summary
Standards, Acceptable Levels of Performance (ALPs)

Task	Objective	Standard	ALP	Positive/Negative Incentives	Surveillance Method/Measure
C.1.11 Timeliness. Complete and return examination reports to VA.	To provide VA timely delivery of examination reports to improve average claims processing timeliness.	35 days average cycle time for all sites combined.	38 days average cycle time for all sites combined for the quarter. If this is met, no positive or negative incentives apply.	**Positive**: 33 days or less average cycle time with at least 66% of the workload completed for the quarter: If this is met for at least three quarters of the contract year, and the ALP is exceeded for quality for at least three quarters of the contract year, then an additional year can be awarded. **Negative:** 39-40 days average cycle time: 1% of total invoiced for quarter will be deducted. Measurement will be rounded up to the next whole number if more than .5. 41 (or more) days average cycle time: 2% of total invoiced for quarter will be deducted. Measurement will be rounded up to the next whole number if more than .5.	Quarterly reports generated by VA's Veterans Examination Request Information System (VERIS). Measured 30 days after the end of each quarter. Discrepancies will be resolved by the VA contracting officer.
C.1.12 Quality. Provide examination reports that meet VA's requirements.	To provide examination reports that meet VA's rating requirements so that rating specialists may use reports to complete rating decisions.	96% quality.	94-96% quality according to VA's examination worksheet requirements. If this is met, then no positive/negative incentives apply.	**Positive:** 98% or higher quality. If this is met for at least three quarters of the contract year, and the timeliness ALP is exceeded for at least three quarters of the contract year, then an additional year can be awarded. **Negative**: 92-93% quality: 1% of the total invoiced for the quarter being measured will be deducted. 91% or below: 2% of the total invoiced for the quarter being measured will be deducted.	Quarterly review by VBA Medical Director and/or board of three VACO rating experts (or a combination). A sample size of approximately 315 randomly selected exam reports (sample size can change depending on number of exam reports delivered in a quarter).
C.1.13 Report Sufficiency Return report corrections to VA	To ensure that insufficient examination reports are			**Positive:** No positive incentives apply. **Negative:** For each insufficient report not returned to	VERIS reports generated on a quarterly basis.

within 14 calendar days.	returned to VA timely.			VA within 14 calendar days, a 5% deduction of the total invoiced for that exam request will apply.	
C.1.8 Customer Satisfaction. Examine veterans within one hour of appointment time.	To ensure that veterans are seen within one hour of the scheduled appointment time.	98% of the time.	92% of the time. If this is met, no positive or negative incentives will apply.	**Positive:** 93-95% of the time seen within one hour: .25% of the total invoiced for the period being measured. 96% (or higher) of the time seen within one hour: .5% of the total invoiced for the period being measured. **Negative:** 85-90% of the time seen within one hour: .25% of the total invoiced for the period will be deducted. 84% and below: .5% of the total invoiced for the period will be deducted.	Customer Survey conducted with VA ongoing throughout contract period.
C.1.12, C.1.13, and C.1.15 Customer Satisfaction Overall satisfaction with contractor's services.	To ensure that veterans are satisfied with the contractor's services to include: scheduling, notification, and examination.	100% satisfied.	92% of the time satisfied.	**Positive:** 93-95% of the time "very" satisfied with contractor's services: .25% of the total invoiced for the period being measured. 96% (or higher) of the time "very" satisfied with the contractor's services: .5% of the total invoiced for the period being measured. **Negative:** 85-90% of the time "very" dissatisfied with the contractor's services: .25% of the total invoiced for the period being measured will be deducted. 84% (and below) of the time "very" dissatisfied with the contractor's services: .5% of the total invoiced for the period being measured will be deducted.	Customer Survey conducted with VA ongoing throughout contract period.

Exhibit No. 2
Quality Assurance Surveillance Plan
For Contract XXXXX

I. Objective

This plan provides a quality surveillance strategy for disability examinations performed for the US Department of Veterans Affairs (VA), Veterans Benefits Administration (VBA). The primary intent of the plan is to provide a basis for the contracting officer's technical representative's (COTR) evaluation of performance quality. Oversight of contractor performance will assure contract quality and consistency of services provided to VBA and the veteran. The plan will also afford the COTR a proactive mechanism to preclude major deficiencies in performance and provide input for annual past performance evaluations.

II. Performance Indicators (Measures)

a. Timeliness. The COTR will determine whether the contractor has consistently satisfied the acceptable level of performance per contractual requirements. The timeliness standard for completing examination requests is specified in C.1.11.

b. Quality. The COTR will determine whether the contractor has consistently satisfied the acceptable level of performance for documenting examination reports per VA examination worksheet specifications. The quality standard for ensuring that all examination reports are compliant with the VA examination worksheets is specified in C.1.12.

c. Report Corrections. The COTR will determine whether the contractor has consistently satisfied the acceptable level of performance for returning insufficient reports to VA in a timely manner. The standard for returning insufficient examination reports to VA is in C.1.13.

d. Customer Satisfaction. The COTR will determine whether the contractor has consistently satisfied the acceptable level of performance for ensuring that veterans are seen by physicians within one hour of appointment time, and that veterans' are satisfied with the contractor's services. The standards for customer satisfaction are found in C.1.3, C.1.6, C.1.8, C.1.14, C.1.17, and C.1.18.

III. Evaluation Methods

The COTR will perform evaluations based on the indicators in paragraph II of this plan. The COTR will initiate the following surveillance techniques.

a. Random inspections. The COTR will perform random visual inspections at least once a year at all of the contractor's sites that perform functions for VA under this contract. A minimum of one site will be included in each inspection, unless specific areas have been targeted for surveillance. A targeted area is one that has received multiple complaints or that needs special attention by the contractor for any reason. The COTR will inform the contractor of any discrepancies found against performance standards. The COTR will maintain records of all inspections and provide a copy of any report to the contractor.

b. Quarterly quality reviews. The VBA Medical Director will conduct a quarterly quality review of a random sample of the contractor's completed examination reports based on the requirements of the VA examination worksheets. The VBA Medical Director will share the results of the reviews with the COTR and contractor and be available to the contractor to explain the findings with the contractor's employees.

c. Veterans Examination Request Information System (VERIS). The COTR will generate quarterly reports for quality and timeliness from the VBA Intranet tool that is used by rating specialists to enter examination requests and record timeliness and quality information. This tool measures the

timeliness based on date that the request is actually sent to the contractor, to the date it is logged in as complete and available to VBA. The contractor provides the completion date to be entered into the application, but the completed examination report must be delivered (or posted) to VA on that date.

d. Customer Satisfaction. An annual customer satisfaction survey is performed. An independent contractor will be responsible for receiving the completed questionnaires and tabulating the results for the COTR's review. Quarterly results will also be provided to the contractor so that any customer satisfaction area requiring attention can be addressed by the contractor. Veterans' responses to these questions will become the basis for the COTR to determine if incentives or deductions are to be applied according to the ALPs.

Exhibit No. 3
Questions/Answers

CONTRACT MEDICAL DISABILITY EXAMS
RFP

QUESTIONS/ANSWERS

GENERAL ACQUISITION OUESTIONS:

INFORMATION TECHNOLOGY AND COMMUNICATIONS:

1. What kind of e-mail system would be in use by the VA for the project?

   The Veterans Benefits Administration (VBA) uses Microsoft Exchange 4.0 electronic mail system as its "departmental" messaging system. We have a Simple Mail Transfer Protocol (SMTP) gateway in operation which permits electronic messages to be sent from VBA personnel to external mail boxes on the Internet and visa versa. At the present time, there are no security measures in place to protect the privacy of data transmitted via electronic mail. For this project, secure transmission of data is necessary due to the private nature of the data.

2. Is it MIME compliant for attachments?

   Yes, according to Microsoft's Technet, Exchange 4.0 supports Multipurpose Internet Mail Extensions (MIME) and is MIME-compliant.

3. Do you expect WAN (Wide Area Network) access to our scheduling system?

   Yes, all participating VBA Regional Offices will need on-line access to the vendor's scheduling system and exam request facilities. The vendor must present a fully functional connectivity solution that includes all access components. The VBA has an internal use WAN, called the Integrated Data Communications Utility (IDCU), which is a private, packet switched network.

4. If yes, how many simultaneous users?

   VBA estimates 530 potential total users over the life of the contract. About 300 users (all current rating specialists, hearing officers, and a station project coordinator at each site) will require access from their desktop in the initial pilot. We estimate about 50 simultaneous users during peak production hours.

5. If you desire modem access, how many simultaneous users?

VBA does not require modems as a connection strategy and it is not preferred; however, it is recognized as a reasonable approach to the requirement. If modems are proposed, then the vendor must provide each user with a modem or access to a modem pool at the VBA site as well as the vendor's host site. The requirement is that VBA personnel must be able to conduct business with the contract provider without having to leave their desktop workstation and go to another workstation. Of the estimated 300 Rating Specialist and Decision Review Officers who will participate in the study, we project that there will be about 50 simultaneous users during production hours.

6. Would you prefer WEB browser access with password protection? Do the claims staff use a browser, and if so, what type and version?

VBA prefers a WEB based technical solution. Password protection and encrypted transmission of data is necessary to ensure the privacy of data. The VBA standard browser is Microsoft Internet Explorer 5.5 in conjunction with Microsoft TCP/IP for Windows 95 and Softronic's Softerm 4.00.02 for terminal emulation.

7. How will the examination requests be sent to the contractor?

VBA rating specialists use an Intranet tool called VERIS (Veterans Examination Request Information System). All new requests are identified as status "1" and are rolled up by the application every morning, encrypted and e-mailed to the contractor over the Internet in a text file format. A back up plan will also need to be developed by the contractor and VBA when Internet e-mail is not available due to technical difficulties.

8. Is toll-free access expected for Veterans to call on us?

Yes. We would expect toll-free service for veterans to contact the contractor with questions pertaining to their scheduled examinations during normal business hours.

9. Would the VA make calls to us at their expense or also expect toll-free service?

No. VA calls will be at government expense.

10. Would most communication with the VA for scheduling purposes be performed via computer, phone or fax?

Routine scheduling would be by computer.

BILLING:

11. How many examinations will be included in each order?

    It depends. Daily examination requests have been as low as 200 and as high as 400 due to VBA's workload peaks. We would expect this trend to remain for at least the next two years, but would not expect it to drop to below 200 per day.

12. In what intervals or batches should examinations be billed?

    Invoices shall be submitted monthly or bi-monthly to the VBA COTR and project manager in an electronic format.

13. Do you have sample invoices that can be furnished?

    No.

14. What sort of supporting documentation would accompany a fund transfer?

    The paying office sends the transfer to your bank along with the invoice number, contract number, and dollar amount. The bank notifies their customer, i.e. you. It was recommended that you talk to the ACB coordinator at your bank to find out the exact details of how they handle it.

CONSULTANT RECRUITING/SCHEDULING/TRAINING and OPERATIONS:

15. Can you provide the most common worksheets requested?

    Yes. Below is the volume of the twelve most common worksheets requested during the period May 1, 2001 through April 30, 2002:

Worksheet	Volume
Joints	**6,001**
Hearing	**4,635**
Spine	**4,468**
General Medical	**4,388**
Diabetes Mellitus	**2,781**
Mental Disorders	**2,034**
Eye Exam	**1,615**
PTSD (To Establish)	**1,605**
Hypertension	**1,475**
Feet	**1,370**
Skin Diseases	**1,238**
PTSD (Follow Up Exam)	**1,232**

16. What is the percentage of exams that require more than one physician?

With the exception of specialist examinations (for which separate billing is provided) a single physician should be able to complete all required examination worksheets.

17. Please clarify what percentage of examination requests are multi-exams.

Each examination requests generally equates to 1.3 examinations to complete the request.

18. How many medical records in pages are provided on average?

Claims folder (original) containing available medical records will be provided. Volume of medical records will range significantly depending on circumstances of the claim including treatment history, and whether the examination is for an original claim, reopened claim or appellate issue. Currently, claims folders are sent for at least psychiatric evaluations, requests for medical opinions, appellate review and most requests for specialist reviews. Some claims folders can be several inches thick, but only the medical records, and other pertinent documentation, will need to be scanned.

19. Will the records be in paper form, microfiche, or electronic?

Records will be provided in paper form (originals requiring return to the sending station).

20. How long are records to be retained?

If the question refers to VA records submitted for review, they should be returned as soon as the examiner has completed his report but no later than five (5) days after completion of the examination report. If the question refers to how long the Contractor should maintain an examination report and supporting data, the answer is a minimum of one year.

21. Are the VA records that are to be forwarded to the contractor the original records? If so, does the VA or contractor assume responsibility if they are lost in the mail? Also, following the examinations, is the VA or the contractor the custodian of the examination reports?

Yes, original records will be furnished. The contractor would not be responsible for records lost in the mail. However, protecting records in the contractor's possession including the privacy of those records would be considered a contractor responsibility, and failure to do so would be considered performance deficiency. The examination reports must be maintained by the contractor for a period of one year. The VA will print the reports received, associate the report with the veteran's

claims folder where it will permanently reside. The contractor is not considered the custodian of the record. The VA is the custodian and any requests directed to the contractor for claimant information should be directed to the regional office of record for processing.

22. Are the tests that are included in the exam to be performed prior to the exam? Is the examining physician expected to review test results such as X-rays?

Scheduling of tests will be left to contractor discretion. In some instances a determination of required test may not be made until after the physician has conducted an examination, but yes, the physician's findings and diagnosis should include a review of test results.

23. If further testing is required, is the patient to return to the examining physician for further review?

As needed only (often a physician should be able to complete his report with review of the test results), but if further physician review (examination) is required, it should be by the same physician if possible.

24. Are any of the tests to be performed at VA facilities?

No.

25. You ask that 7 days be allowed for scheduling. Do you have a window that you prefer?

The veteran must be given timely notification of the scheduled appointment.

26. From compliance and incentive standpoint, does the clock start from the time of the first call for an examination by the VA, the date of the exam, or when labs are finished? (Realize that if an exam is for example scheduled in 14 days, and lab/X-rays are required, that to meet the optimum time frame, there is very little time to produce the report. Certain studies such as MRI's, cardiac studies and others might not be able to be scheduled the same day, and require several days for results.)

The clock starts from the time the contractor receives the daily file containing the examination requests until the date the VA receives the completed examination report. We recognized that in some instances examinations may take longer to process and allow for that by measuring based on <u>AVERAGE</u> processing days.

27. Are we expected to notify the Veterans of the examination by mail, phone or both? How is it currently done?

The contractor may use mail, phone, e-mail or a combination of all to notify the veteran of the examination date and time. We prefer a combination so that "no shows" can be kept to a minimum.

28. Should no-shows and late cancels be automatically rescheduled? With or without VA knowledge and/or consent?

One reschedule is allowed. If the veteran is a no show, and does not contact the contractor the day after the scheduled appointment to request a reschedule, then the regional office must be notified by e-mail that the veteran was a no show and no further attempt to contact the veteran is necessary. However, if the veteran does contact the contractor and request to be rescheduled, then one reschedule is allowed. The contractor may also "code" this request as a "reschedule" so that the examination request cycle time is not counted against the contractor for accommodating the veteran.

29. If a veteran calls in advance to rearrange an examination within a reasonable period (e.g. one week), is this permissible?

Yes.

30. Are we expected to determine service connectedness as well as diagnosis?

No. The determination of service connection is the responsibility of the VBA rating specialist. You may however, be asked to offer specific opinions such as "are current symptoms related to condition [specified] documented during military service?" Or, "is the condition as least as likely or not related to service?" (Service medical records and available post service treatment records would be provided for review.) Or, "is there a causal relationship between a service connected left knee condition and current low back complaints?"

31. Please discuss the nature of the disability exams; philosophy, reference material used by physicians, length of exam, amount of narrative, etc.

Disability examinations are to be approached in a positive manner. When issues arise where reasonable doubt exists, that doubt should be decided in the veteran's favor. The examination in addition to etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, should fully describe the effects of disability upon the person's ordinary activity.

The basic guideline for examinations is the Compensation and Pension Examination Worksheets. The length of examination should be governed by the time required to obtain the information specified in the relevant worksheet, including appropriate history and complaints. Concise narrative, including required findings, and any other information directly pertinent to

the issue is preferred. Unnecessarily redundant or expansive narratives should be avoided.

32. If the veteran asks for a copy of the report, should it be provided?

No. The veteran should be advised to obtain a copy from the VA regional office handling the veteran's claim.

33. If a release signed by the veteran and/or subpoena is received for the report, should it be provided with or without the VA knowledge and/or consent?

No. The VA is the custodian of the record and all requests should be forwarded to the regional office of record for response.

34. Should the consultants be specifically proscribed as to offering treatment for the veterans that they examine?

If treatment is necessary, then the regional office should be notified so that treatment can be arranged at the closest VA medical center or clinic. If urgent care is needed, then a referral can be made with notification to VA for follow up.

35. Do these examinations become part of the Veteran's medical record file?

They become a permanent part of the Veteran's VA claims folder. They will be available for appellate review by the Board of Veterans Appeal (BVA), U.S. Court for Veterans Appeals, and regional office review in conjunction with any future reviews (either based on a reopened claim or other future review). They will not be routinely forwarded to VA's Veterans Health Administration unless a VA medical center requests a copy of the report.

36. While examination reports are to be conveyed electronically, does the VA desire a hard copy as well to be mailed?

No.

37. Copies of labs, photos, X-rays and other studies would be mailed separately from the electronically submitted reports. Is this what is expected?

No. It is preferred that they be transmitted in .pdf format along with the examination report electronically. The actual x-rays are not routinely required; the narrative report (reading) is sufficient, unless otherwise specified.

38. Is there an average size in words or pages of a report for given specialties?

No. We seek concise reports that convey all the required information per the examination worksheets.

39. Do you have some sample reports that demonstrate your concept of excellence?

No. We believe the Compensation and Pension Examination Worksheets are the best "guide" to the information necessary to present an excellent examination report.

ADMINISTRATIVE and OTHER:

40. What are the VA's current internal costs per examination? Do these include laboratory and x-ray?

The internal cost of conducting an examination for disability evaluation purposes is not yet available.

41. What are the main problems currently faced with the internal system now in place?

Current problems include uneven examination quality and processing timeliness.

42. Do you intend to increase the size of the contract during the course of it?

Not at the present time.

43. Does the government anticipate an immediate full caseload from the ten regional office and their Benefits Delivery at Discharge (BDD) sites as of May 1, 2003?

Yes. The contractor should be ready to take the full caseload by this date.

44. Will the government provide relevant training materials and/or collaborative consultation to assist us in developing proper training on the VA system, and its policies and requirements?

Yes. Existing materials developed to assist VA physicians will be reviewed and adapted for this purpose. Additional information required to introduce physicians and others to the VA, our programs, and resources will be developed and provided.

45. Do you have any estimates of the percent of veterans who are entitled to and who claim travel allowance to attend examinations, and the average cost for those who are reimbursed?

Most veterans would be eligible for travel allowance for attending examinations. The average cost will depend greatly on a contractor's ability to schedule examinations relatively close to the veteran's home of record, since payments are based on rate per mile traveled.

46. How many VA staff would we be likely to interact with on a regular basis?

Each of the ten regional offices has one examination coordinator who is the primary contact for the contractor for inquiries and clarification as it pertains to the daily workload file. In addition, a VBA project manager is assigned, as well as a COTR who the contractor will be in routine contact.

47. Do hearing exams have to be performed with all general medical examinations?

No. A specific audiology examination would only be required if hearing loss was specified as a condition to be examined, or if during the general clinical assessment, hearing impairment was established or suspected. Hearing examinations must be performed by a licensed audiologist using the Maryland CNC test.

48. What percentage of non-specialist exams require a specialist exam?

For examinations in areas other than psychiatry, dental, ophthalmology, audiology, and neurology, specialty requests will be the exception and not the norm. While a specialist will not be required for all neurological issues, specialists will be required in this area more often than not. However, for example, when checking for peripheral neuropathy as a complication of diabetes, a specialist will not generally be required. Usually, in other areas, specialist examinations will be requested when a case has been appealed and a specialist examination is directed by the Board of Veterans Appeals, or when there is conflicting medical evidence of record which requires resolution. Specific percentages have not been documented.

49. Is additional medical opinion/recommendation such as apportionment, causation and return to work status required in each report, and if so, is it included in the unit price.

Routine information required in each worksheet will be included in the examination price. Medical opinions, questions that the physician can respond to based on examination of the veteran, not requiring extensive review of medical records will also be included in the basic exam price. A separate charge may be added for specific requested "independent medical opinions" requiring review of the available medical records and a formal written opinion including citation of the pertinent facts found on the medical record review.

50. The contractor must bear the cost of postage for the customer survey cards. Do they have to be mailed via first class postage to the independent contractor?

No, as long as the cards can be received by the independent contractor within a two-week period once placed into the US Postal Service system by the veteran.

Exhibit No. 4
Compensation and Pension Examination Worksheets

GENERAL MEDICAL EXAMINATION

Name: SSN:

Date of Exam: C-number:

Place of Exam:

Narrative: This is a comprehensive base-line or screening examination for all body systems, not just specific conditions claimed by the veteran. It is often the initial post-discharge examination of a veteran requested by the Compensation and Pension Service for disability compensation purposes. As a screening examination, it is not meant to elicit the detailed information about specific conditions that is necessary for rating purposes. **Therefore, all claimed conditions, and any found or suspected conditions that were not claimed, should be addressed by referring to and following all appropriate worksheets, in addition to this one, to assure that the examination for each condition provides information adequate for rating purposes**. This does not require that a medical specialist conduct examinations based on other worksheets, except in the case of vision and hearing problems, mental disorders, or especially complex or unusual problems. **VISION, HEARING, AND MENTAL DISORDER EXAMINATIONS MUST BE CONDUCTED BY A SPECIALIST**. The examiner may request any additional studies or examinations needed for proper diagnosis and evaluation (see other worksheets for guidance). All important negatives should be reported. The regional office may also request a general medical examination as evidence for nonservice-connected disability pension claims or for claimed entitlement to individual unemployability benefits in service-connected disability compensation claims. Barring unusual problems, examinations for pension should generally be adequate if only this general worksheet is followed.

A. **Review of Medical Records:** Indicate whether the C-file was reviewed.

B. **Medical History (Subjective Complaints):**

1. Discuss: Whether an injury or disease that is found occurred during active service, before active service, or after active service. To the extent possible, describe the circumstances, dates, specific injury or disease that occurred, treatment, follow-up, and residuals. If the injury or disease occurred before active service, describe any worsening of residuals due to being in military service. Describe current symptoms and treatment.
2. Occupational history (for pension and individual unemployability claims): Obtain the name and address of employers (list most current first), type of occupation, employment dates, and wages for last 12 months. If any time was lost from work in the past 12-month period, please describe the reason and extent of time lost.
3. Describe details of current treatment, conditions being treated, and side effects of treatment.
4. Describe all surgery and hospitalizations in and after service with approximate dates.
5. If a malignant neoplasm is or was present, provide:
    a. Date of confirmed diagnosis.
    b. Date of the last surgical, X-ray, antineoplastic chemotherapy, radiation, or other therapeutic procedure.
    c. State expected date treatment regimen is to be completed.
    d. If treatment is already completed, provide date of last treatment.
    e. If treatment is already completed, fully describe residuals.

C. Physical Examination (Objective Findings):
Address each of the following and fully describe current findings: The examiner should incorporate results of all ancillary studies into the final diagnoses.

1. VS: Heart rate, blood pressure (see #13 below), respirations, height, weight, maximum weight in past year, weight change in past year, body build, and state of nutrition.
2. Dominant hand: Indicate the dominant hand and how this was determined, e.g., writes, eats, combs hair with that hand.
3. Posture and gait: Describe abnormality and reason for it. Describe any ambulatory aids.
4. Skin, including appendages: If abnormal, describe appearance, location, extent of lesions. If there are laceration or burn scars, describe the location, exact measurements (cm. x cm.), shape, depression, type of tissue loss, adherence, and tenderness. For each burn scar, state if due to a 2nd or 3rd degree burn. Describe any limitation of activity or limitation of motion due to scarring or other skin lesions. **NOTE:** If there are disfiguring scars (of face, head, or neck), obtain color photographs of the affected area(s) to submit with the examination report.
5. Hemic and Lymphatic: Describe adenopathy, tenderness, suppuration, edema, pallor, etc.
6. Head and face: Describe scars, skin lesions, deformities, etc., as discussed under item #4.
7. Eyes: Describe external eye, pupil reaction, eye movements.
8. Ears: Describe canals, drums, perforations, discharge.
9. Nose, sinuses, mouth and throat: Include gross dental findings. For sinusitis, describe headaches, pain, episodes of incapacitation, frequency and duration of antibiotic treatment.
10. Neck: Describe lymph nodes, thyroid, etc.
11. Chest: Inspection, palpation, percussion, auscultation. Describe respiratory symptoms and effect on daily activities, e.g., how far the veteran can walk, how many flights of stairs veterans can climb. If a respiratory condition is claimed or suspected, refer to appropriate worksheet(s). Most respiratory conditions will require PFT's, including post-bronchodilation studies. Describe in detail any treatment for pulmonary disease.
12. Breast: Describe masses, scars, nipple discharge, skin abnormalities. Give date of last mammogram, if any. Describe any breast surgery (with approximate date) and residuals.
13. Cardiovascular : NOTE: If there is evidence of a cardiovascular disease, or one is claimed, refer to appropriate worksheet(s).
    a. Record pulse, quality of heart sounds, abnormal heart sounds, arrhythmias. Describe symptoms and treatment for any cardiovascular condition, including peripheral arterial and venous disease. Give NYHA classification of heart disease. A determination of METs by exercise testing may be required for certain cardiovascular conditions, and an estimation of METS may be required if exercise testing cannot be conducted for medical reasons. (See the cardiovascular worksheets for further guidance.)
    b. Describe the status of peripheral vessels and pulses. Describe edema, stasis pigmentation or eczema, ulcers, or other skin or nail abnormalities. Describe varicose veins, including extent to which any resulting edema is relieved by elevation of extremity. Examine for evidence of residuals of cold injury when indicated. See and follow special cold injury examination worksheet if there is a history of cold exposure in service and the special cold injury examination has not been previously done.
    c. **BLOOD PRESSURE:** (Per the rating schedule, hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.)
        1) If the diagnosis of hypertension has not been previously established, and it is a claimed issue, B.P. readings must be taken two or more times on each of at least three different days.
        2) If hypertension has been previously diagnosed and is claimed, but the claimant is not on treatment, B.P. readings must be taken two or more times on at least three different days.
        3) If hypertension has been previously diagnosed, and the claimant is on treatment, take three blood pressure readings on the day of the examination.

4) If hypertension has not been claimed, take three blood pressure readings on the day of the examination. If they are suggestive of hypertension or are borderline, readings must be taken two or more times on at least two additional days to rule hypertension in or out.
5) In the diagnostic summary, state whether hypertension is ruled in or out after completing these B.P. measurements. Describe treatment for hypertension and side effects. If hypertensive heart disease is suspected or found, follow worksheet for Heart.

14. Abdomen: Inspection, auscultation, palpation, percussion. Describe any organ enlargement, ventral hernia, mass, tenderness, etc.
15. Genital/rectal (male): Inspection and palpation of penis, testicles, epididymis, and spermatic cord. If there is a hernia, describe type, location, size, whether complete, reducible, recurrent, supported by truss or belt, and whether or not operable. Describe anal fissures, hemorrhoids, ulcerations, etc. Include digital exam of rectal walls and prostate.
16. Genital/rectal (female): Pelvic exam, including inspection of introitus, vagina, and cervix, palpation of labia, vagina, cervix, uterus, adnexa, and ovaries, rectal exam. Do Pap smear if none within past year. If unable to conduct an examination and Pap smear, or if there is a severe or complex problem, refer to a specialist.
17. Musculoskeletal:
    a. For all joint or muscle disorders, state each muscle and joint affected.
    b. Separately examine and describe in detail each affected joint. Measure active and passive range of motion in degrees using a goniometer. In addition, provide an assessment of the effect on range of motion and joint function of pain, weakness, fatigue, or incoordination following repetitive use or during flare-ups. (See the appropriate musculoskeletal worksheet for more detail.) NOTE: The diagnosis of degenerative or traumatic arthritis of any joint requires X-ray confirmation, but once confirmed by X-ray, either in service or after service, no further X-rays of that joint are required for disability evaluation purposes.
    c. Describe swelling, effusion, tenderness, muscle spasm, joint laxity, muscle atrophy, fibrous or bony residual of fracture. If joint is ankylosed, describe the position and angle of fixation.
    d. Describe any mechanical aids used by veteran.
    e. If foot problems exist, also describe objective evidence of pain at rest and on manipulation, rigidity, spasm, circulatory disturbance, swelling, callus, loss of strength, and whether condition is acquired or congenital.
    f. If there is amputation of a part, see the appropriate worksheet.
    g. With disc disease, also describe any neurological findings.
18. Endocrine: Describe signs and symptoms of any endocrine disease, effects on other body systems, and current and past treatment. See endocrine worksheets for further guidance.
19. Neurological: Assess orientation and memory, gait, stance, and coordination, cranial nerve functions. Assess deep tendon reflexes, pain, touch, temperature, vibration, and position, motor and sensory status of peripheral nerves. If neurological abnormalities are found on examination, or there is a history of seizures, refer to appropriate worksheet.
20. Psychiatric: Describe behavior, comprehension, coherence of response, emotional reaction, signs of tension and effects on social and occupational functioning. (This is meant to be a brief screening examination. If a mental disorder is claimed, or suspected based on the screening, an examination for diagnosis and assessment should be conducted by a psychiatrist or psychologist.) State whether the veteran is capable of managing his or her benefit payments in his or her own best interests without restriction. (A physical disability which prevents the veteran from attending to financial matters in person is not a proper basis for a finding of incompetency unless the veteran is, by reason of that disability, incapable of directing someone else in handling the individual's financial affairs.)

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.
2. Review all test results before providing the summary and diagnosis.
3. Follow additional worksheets, as appropriate.

E. **Diagnosis:** Provide a summary list of all disabilities diagnosed. Include an interpretation of the results of all diagnostic and other tests conducted in the final summary and diagnosis. For each condition diagnosed, describe its effect on the veteran's usual occupation and daily activities.

Signature: Date:

Compensation and Pension Examination

BONES (FRACTURES AND BONE DISEASE)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Describe details of any injury, episodes of osteomyelitis, or surgery.
2. Symptoms of pain, weakness, stiffness, swelling, heat, redness, drainage, instability or giving way, "locking," abnormal motion, etc.
3. Treatment: medication type, dose, frequency, response, and side effects; other treatment.
4. If there are periods of flare-up of bone disease:
    a. State their severity, frequency, and duration.
    b. Name the precipitating and alleviating factors.
    c. Estimate to what extent, if any, they affect functional impairment during the flare-up.
5. Is there current active infection? If not, when was the last active infection? How was it determined?
6. Describe whether crutches, brace, cane, corrective shoes, etc., are needed.
7. Are there constitutional symptoms of bone disease?
8. Describe the effects of the condition on the veteran's usual occupation and daily activities.

C. **Physical Examination (Objective Findings):**

Address each of the following as appropriate to the disability being examined and fully describe current findings:

1. Describe objective evidence of deformity, angulation, false motion, shortening, intra-articular involvement, etc.
2. Malunion, nonunion, any loose motion, false joint.
3. Tenderness, drainage, edema, painful motion, weakness, redness, heat.
4. For weight bearing joints (hip, knee, ankle), describe gait and functional limitations on standing and walking. Describe any callosities, breakdown, or unusual shoe wear pattern that would indicate abnormal weight bearing.
5. If ankylosis is present, describe the position of the bones of the joint in relationship to one another (in degrees of flexion, external rotation, etc.), and state whether the ankylosis is stable and pain free.
6. With joint involvement, <u>a detailed assessment of each affected joint is required</u>.
   Note: See worksheet on Shoulder, Elbow, Wrist, Hip, Knee, and Ankle for normal range of motion of those joints.
    a. Using a goniometer, measure the <u>passive</u> and <u>active</u> range of motion, including movement against gravity and against strong resistance.
    b. If the joint is painful on motion, state at what point in the range of motion pain begins and ends.
    c. State to what extent, if any, the range of motion or function is <u>additionally limited</u> by pain, fatigue, weakness, or lack of endurance. If more than one of these is present, state, if possible, which has the major functional impact.

7. If shortening of the leg may be present, measure the leg length from the anterior superior iliac spine to the medial malleolus.
8. Are there constitutional signs of bone disease - anemia, weight loss, fever, debility, amyloid liver, etc.?

D. **Diagnostic and Clinical Tests:**

1. As indicated: X-rays, including special views or weight bearing films, MRI, arthrogram, diagnostic arthroscopy. **Note:** The diagnosis of degenerative arthritis or post-traumatic arthritis of a joint requires X-ray confirmation. Once the diagnosis has been confirmed in a joint, further X-rays of that joint are not required.
2. For osteomyelitis, state whether there is an involucrum, sequestrum, or draining sinus.
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:

Signature: Date:

Compensation and Pension Examination

FIBROMYALGIA

Name: SSN:

Date of Exam: C-number:

Place of Exam:

Narrative: For VA compensation purposes, the diagnosis of fibromyalgia (sometimes called fibrositis, primary fibromyalgia syndrome, or myofascial pain syndrome) requires the presence of widespread musculoskeletal pain and tender points. Additional findings may also be present: fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms. Widespread pain is defined as pain in both the left and right sides of the body, that is both above and below the waist, and that affects both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine, or low back) and the extremities. Rule out other diagnostic entities that may be responsible for the symptomatology presented.

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Date of onset of symptoms, date of diagnosis (if known).
2. What precipitates and alleviates symptoms?
3. Location, severity, frequency of any musculoskeletal pain, stiffness, or muscle weakness, whether episodic or constant, and what their effects are on daily activities
4. Unexplained fatigue, sleep disturbances.
5. GI symptoms.
6. Treatment, (type, duration, response). Has treatment been continuous?
7. Is there depression or anxiety?
8. Lost time from work?

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings: (Please incorporate all ancillary study results into the final diagnosis.)

1. Is the condition currently active or in remission?
2. Musculoskeletal areas involved.
3. Trigger or tender points.
4. Muscle strength in involved areas.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

RESIDUALS OF AMPUTATIONS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. The location of the amputation site.
2. If symptoms exist, describe precipitating factors, aggravating factors, alleviating factors, alleviating medications, frequency, severity, and duration.

C. Physical Examination (Objective Findings):

Address each of the following and fully describe current findings:

1. Swelling, deformity, tenderness of stump.
2. Skin, including scar.
3. Circulation.
4. Muscles
5. Describe any limited motion or instability in the joint above the amputation site.
6. A detailed assessment of each affected joint is required.
    a. Using a goniometer, measure the passive and active range of motion, including movement against gravity and against strong resistance.
    b. If the joint is painful on motion, state at what point in the range of motion pain begins and ends.
    c. State to what extent, if any, the range of motion or function is additionally limited by pain, fatigue, weakness, or lack of endurance. If more than one of these is present, state, if possible, which has the major functional impact.
7. Bones
8. Length of stump
9. Neuroma, if present
10. Is amputation of lower extremity improvable by prosthesis controlled by natural knee action?

Measurement of the Stump:

The stump of an amputated thigh will be measured from the perineum, at the origin of the adductor tendons, to the bony end of the stump, with the claimant recumbent and the stump lying parallel with the other lower limb. It is to be kept in mind that if the limb is abducted, flexed, rotated or adducted, its length will be altered. The effective length of a thigh stump is governed by its inside dimension. Measure length of normal thigh if present and indicate whether amputation is in upper, middle, or lower third. When amputation is bilateral, estimate the same for a person of similar height.

The stump of an amputated leg below the knee must be measured from the insertion of the internal hamstring muscles to the bony end of the stump with the patient recumbent and the leg flexed at 90 degrees.

The stump of an amputated arm should be measured from the anterior axillary fold to the bony end of the stump, with the stump hanging parallel to the chest wall. Indicate whether the amputation site is above or below the insertion of the deltoid muscle. A statement of the remaining function is the best indicator of a disability's severity.

The stump of an amputated forearm should be measured from the insertion of the biceps tendon to the bony end, with the elbow flexed at 90 degrees. Indicate if the amputation site is above or below the attachment of the pronator teres.

Amputations of fingers should be described as through the distal, middle, or proximal phalanx or as disarticulations through the distal interphalangeal, proximal interphalangeal, or metacarpophalangeal joint. Resection of the head of the metacarpal will always be reported if shown. Complete or partial loss or resection of bones of the hand will described in terms of the fraction of each remaining. If surgery has altered the usefulness of remaining or transplanted digits, this will be described.

Complete or partial loss of toes or metatarsal or tarsal bones should be described as in the subparagraph above. Always report loss of metatarsal head or other defects. Indicate if amputation is through the tarsal-metatarsal joint and if any other portions of the bones of the foot remain.

D. **Diagnostic and Clinical Tests:**

1. X-ray if exact amputation level is not of record.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Amputations must be described in accordance with the following levels:

1. ARM:
    a. Disarticulation
    b. Amputation above insertion of deltoid muscle.
    c. Amputation below insertion of deltoid muscle.
2. FOREARM:
    a. Above radial insertion of pronator teres (function is best indicator of disability).
    b. Below insertion of pronator teres.
3. THIGH:
    a. Disarticulation, with loss of extrinsic pelvic girdle muscles.
    b. Amputation of upper, middle or lower third, always measured from perineum to the bony end of the stump with the claimant recumbent and stump lying parallel with the other lower limb.
    c. State whether this level permits satisfactory prosthesis.
4. LEG:
    a. Give level of amputation and condition of stump.
    b. State whether this level permits a satisfactory prosthesis.
    c. Describe any stump defects (e.g., painful neuroma or circulatory disturbance).

Signature: Date:

Compensation and Pension Examination

JOINTS (SHOULDER, ELBOW, WRIST, HIP, KNEE, AND ANKLE)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Pain, weakness, stiffness, swelling, heat and redness, instability or giving way, "locking," fatigability, lack of endurance, etc.
2. Treatment - type, dose, frequency, response, side effects.
3. If there are periods of flare-up of joint disease:
    a. State their severity, frequency, and duration.
    b. Name the precipitating and alleviating factors.
    c. Estimate to what extent, if any, they result in additional limitation of motion or functional impairment during the flare-up.
4. Describe whether crutches, brace, cane, corrective shoes, etc., are needed.
5. Describe details of any surgery or injury.
6. Describe any episodes of dislocation or recurrent subluxation.
7. For inflammatory arthritis, describe any constitutional symptoms.
8. Describe the effects of the condition on the veteran's usual occupation and daily activities.
9. Dominance of extremity and means used to identify dominant extremity.
10. If there is a prosthesis, provide date of prosthetic implant and describe any complaint of pain, weakness, or limitation of motion. State whether crutches, brace, etc., are needed.

C. **Physical Examination (Objective Findings):**

Address each of the following as appropriate to the condition being examined and fully describe current findings: A detailed assessment of each affected joint is required, including joints with prostheses.

1. Using a goniometer, measure the passive and active range of motion, including movement against gravity and against strong resistance. Provide range of motion in degrees.
2. If the joint is painful on motion, state at what point in the range of motion pain begins and ends.
3. State to what extent (if any) and in which degrees (if possible) the range of motion or joint function is additionally limited by pain, fatigue, weakness, or lack of endurance following repetitive use or during flare-ups. If more than one of these is present, state, if possible, which has the major functional impact.
4. Describe objective evidence of painful motion, edema, effusion, instability, weakness, tenderness, redness, heat, abnormal movement, guarding of movement, etc.
5. For weight bearing joints (hip, knee, ankle), describe gait and functional limitations on standing and walking. Describe any callosities, breakdown, or unusual shoe wear pattern that would indicate abnormal weight bearing.
6. If ankylosis is present, describe the position of the bones of the joint in relationship to one another (in degrees of flexion, external rotation, etc.), and state whether the ankylosis is stable and pain free.

7. If indicated, measure the leg length from the anterior superior iliac spine to the medial malleolus.
8. For inflammatory arthritis, describe any constitutional signs.
9. Describe range of motion with prosthesis in same detail as described above for nonprosthetic joints.

D. **Normal Range of Motion:** All joint Range of Motion measurements must be made using a **goniometer**. Show each measured range of motion separately rather than as a continuum. For example, if the veteran lacks 10 degrees of full knee extension and has normal flexion, show the range of motion as extension to minus 10 degrees (or lacks 10 degrees of extension) and flexion
0 to 140 degrees.

1. Hip range of motion: (Movement of femur as it rotates in the acetabulum.)
    a. Normal range of motion, using the anatomical position as zero degrees.
    Flexion = 0 to 125 degrees (To gain a true picture of hip flexion, i.e., movement between the pelvis and femur in the hip joint, the opposite thigh should be extended to minimize motion between the pelvis and spine.)
    Extension = 0 to 30 degrees.
    Adduction = 0 to 25 degrees.
    Abduction = 0 to 45 degrees.
    External rotation = 0 to 60 degrees.
    Internal rotation = 0 to 40 degrees.

2. Knee range of motion:
    a. Normal range of motion, using the anatomical position as zero degrees.
    Flexion = 0 to 140 degrees.
    Extension - zero degrees = full extension. Show loss of extension by describing the degrees in which extension is not possible. (e.g., Show range of motion as extension to minus 10 degrees and flexion 0 to 140 degrees when full extension is limited by 10 degrees and full flexion is possible.)
    b. Stability.
    Medial and Lateral Collateral Ligaments: Varus/valgus in neutral and in 30 degrees of flexion - normal is no motion.
    Anterior and Posterior Cruciate Ligaments: Anterior/posterior in 30 degrees of flexion with foot stabilized - normal is less than 5 mm. of motion (1/4 inch - Lachman's test) or in 90 degrees of flexion with foot stabilized - normal is less than 5mm. of motion (1/4 inch - anterior and posterior drawer test).
    Medial and Lateral Meniscus: Perform McMurray's test.

3. Ankle range of motion:
    a. Neutral position is with foot at 90 degrees to ankle. From that position, dorsiflexion is 0 to 20 degrees; plantar flexion is 0 to 45 degrees.
    b. Describe any varus or valgus angulation of the os calcis in relationship to the long axis of the tibia and fibula.

4. Shoulder, elbow, forearm, and wrist range of motion:
    a. Normal range of motion is measured with zero degrees the anatomical position except for 2 situations:
        (1) Supination and pronation of the forearm is measured with the arm against the body, the elbow flexed to 90 degrees, and the forearm in mid position (zero degrees) between supination and pronation.
        (2) Shoulder rotation is measured with the arm abducted to 90 degrees, the elbow flexed to 90 degrees, and the forearm reflecting the midpoint (zero degrees) between internal and external rotation of the shoulder.

b. Shoulder forward flexion = zero to 180 degrees.
c. Shoulder abduction = zero to 180 degrees.
d. Shoulder external rotation = zero to 90 degrees.
e. Shoulder internal rotation = zero to 90 degrees.
f. Elbow flexion = zero to 145 degrees.
g. Forearm supination = zero to 85 degrees.
h. Forearm pronation = zero to 80 degrees.
i. Wrist dorsiflexion (extension) = zero to 70 degrees.
j. Wrist palmar flexion = zero to 80 degrees.
k. Wrist radial deviation = zero to 20 degrees.
l. Wrist ulnar deviation = zero to 45 degrees.

E. **Diagnostic and Clinical Tests:**

1. As indicated: X-rays, including special views or weight bearing films, MRI, arthrogram, diagnostic arthroscopy.

Note: The diagnosis of degenerative arthritis or post-traumatic arthritis of a joint requires

2. Include results of all diagnostic and clinical tests in the examination report.

X-ray confirmation. Once the diagnosis has been confirmed in a joint, further X-rays of that joint are not required.

F. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

HAND, THUMB, AND FINGERS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. If there are periods of flare-up of joint disease:
    a. State their severity, frequency, and duration.
    b. Name the precipitating and alleviating factors.
    c. Estimate to what extent, if any, they result in additional limitation of motion or functional impairment during the flare-up.

C. **Physical Examination (Objective Findings):**

Address each of the following as appropriate to the condition being examined and fully describe current findings:

1. Anatomical defects.
2. Functional defects (motion of thumb and fingers should be described as to how near, in inches, the tip of thumb can approximate the fingers, or how near the tips of fingers can approximate the median transverse fold of the palm.
3. Grasping objects (strength and dexterity).

The hand should be evaluated as a unit intricately adapted for grasping, pushing, pulling, twisting, probing, writing, touching, and expression. Do not designate fingers numerically; use thumb, index, middle (or long), ring, and little. Specify which hand is involved and state whether the individual is right- or left-handed. Designate the joints as wrist, MP (metacarpophalangeal), PIP (proximal interphalangeal), or DIP (distal interphalangeal). Designate phalanges as proximal, middle or distal.

4. <u>A detailed assessment of each affected joint is required</u>.
    a. Using a goniometer, measure the <u>passive</u> and <u>active</u> range of motion, including movement against gravity and against strong resistance.
    b. State to what extent (if any) and in which degrees (if possible) the range of motion or joint function is <u>additionally limited</u> by pain, fatigue, weakness, or lack of endurance following repetitive use or during flare-ups. If more than one of these is present, state, if possible, which has the major functional impact.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

FEET

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Pain, weakness, stiffness, swelling, heat, redness, fatigability, lack of endurance, etc. Describe symptoms at rest and on standing and walking.
2. Treatment - type, dose, frequency, response, side effects.
3. If there are periods of flare-up of joint disease:
    a. State their severity, frequency, and duration.
    b. Name the precipitating and alleviating factors.
    c. Estimate to what extent, if any, they result in additional limitation of motion or functional impairment during the flare-up.
4. Describe whether crutches, brace, cane, corrective shoes, etc., are needed.
5. Describe details of any surgery or injury.
6. Describe corrective shoes, shoe inserts, or braces used and their efficacy.
7. Describe effects of the condition(s) on the veteran's usual occupation and daily activities.

C. **Physical Examination (Objective Findings)**

Address each of the following as appropriate to the condition being examined and fully describe current findings: A detailed assessment of each affected joint is required.

1. Describe each foot separately. For nomenclature of toes use: great toe, second, third, fourth, and fifth. The functional loss should be related to the anatomical condition.
2. Using a goniometer, measure the passive and active range of motion, including movement against gravity and against strong resistance.
3. If the joint is painful on motion, state at what point in the range of motion pain begins and ends.
4. State to what extent (if any) and in which degrees (if possible) the range of motion or function is additionally limited by pain, fatigue, weakness, or lack of endurance following repetitive use or during flare-ups. If more than one of these is present, state, if possible, which has the major functional impact.
5. Describe objective evidence of painful motion, edema, instability, weakness, tenderness, etc.
6. Describe gait and functional limitations on standing and walking.
7. Describe any callosities, breakdown, or unusual shoe wear pattern that would indicate abnormal weight bearing.
8. Describe any skin and vascular changes.
9. Posture on standing, squatting, supination, pronation, and rising on toes and heels.
10. Describe hammertoes, high arch, clawfoot, or other deformity - actively or passively correctable?
11. For flatfoot
    a. Describe weight bearing and non-weight bearing alignment of the Achilles tendon.
    b. Describe whether the Achilles tendon alignment can be corrected by

manipulation and whether there is pain on manipulation.

c. Describe degrees of valgus and whether correctable by manipulation.

d. Describe extent of forefoot and midfoot malalignment and whether correctable by manipulation.

12. For hallux valgus, describe angulation and dorsiflexion at first metatarso-phalangeal joints.

D. **Diagnostic and Clinical Tests:**

Comment on:

1. X-rays for flatfoot and clawfoot - weight bearing AP and lateral views and non-weight bearing AP, lateral, and oblique views.
2. For other conditions, AP lateral and oblique of entire foot as applicable.
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

SPINE (CERVICAL, THORACIC, AND LUMBAR)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Present Medical History (Subjective Complaints):**

Comment on:

1. Complaints of pain, weakness, stiffness, fatigability, lack of endurance, etc.
2. Treatment - type, dose, frequency, response, side effects
3. If there are periods of flare-up:
    a. State their severity, frequency, and duration.
    b. Name the precipitating and alleviating factors.
    c. Estimate to what extent, if any, they result in additional limitation of motion or functional impairment during the flare-up.
4. Describe whether crutches, brace, cane, etc., are needed.
5. Describe details of any surgery or injury.
6. Functional Assessment - Describe effects of the condition(s) on the veteran's usual occupation and daily activities.

C. **Physical Examination (Objective Findings):**

Address each of the following as appropriate to the condition being examined and fully describe current findings:

1. Using a goniometer, measure the passive and active range of motion, including movement against gravity and against strong resistance. Provide range of motion in degrees.
2. If the spine is painful on motion, state at what point in the range of motion pain begins and ends.
3. State to what extent (if any) and in which degrees (if possible) the range of motion or spinal function is additionally limited by pain, fatigue, weakness, or lack of endurance following repetitive use or during flare-ups. If more than one of these is present, state, if possible, which has the major functional impact.
4. Describe objective evidence of painful motion, spasm, weakness, tenderness, etc.
5. Postural abnormalities, fixed deformity.
6. Musculature of back.
7. Neurological abnormalities - if present, see appropriate worksheet.

D. **Normal Range of Motion:** All joint Range of Motion measurements must be made using a **goniometer**. Show each measured range of motion separately rather than as a continuum.

E. **Diagnostic and Clinical Tests:**

Obtain the following and comment on them, as indicated:

1. X-rays, MRI, as indicated.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

F. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

MUSCLES

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. If there are periods of flare-up of residuals of muscle injury:
    a. State their severity, frequency, and duration.
    b. Name the precipitating and alleviating factors.
    c. Estimate to what extent, if any, they result in additional limitation of motion or functional impairment during the flare-up.
2. If injury is due to a missile: initial treatment in the field, length of initial hospitalization and any surgeries or other repairs undertaken, time for return to duty or limited duty or determination that duty could not be resumed.
3. Record exact muscles injured or destroyed and describe.
4. Record any associated injuries, particularly those affecting bony structures, nerves or vascular structures and specify the nature of treatment required.
5. Describe present symptoms of muscle pain, activity limited by fatigue or inability to move joint through a portion of its range; and the degree to which this interferes with activities of daily living.
6. For tumors of muscle, describe onset of symptoms, date(s) of biopsy and/or surgical excision and residual defects. If malignant neoplasm, need date of diagnosis, dates and type of treatment, and date of last treatment.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Entry and exit wound scars as well as dimensions.
2. Tissue loss comparison, and specify muscle group(s) penetrated.
3. Scar formation measurement (sensitivity, tenderness, etc.)
4. Adhesions.
5. Tendon damage.
6. Bone, joint or nerve damage.
7. Muscle strength.
8. Muscle herniation and, if any, if supported by a truss or belt.
9. Loss of muscle function. Can muscle group move joint through normal range with sufficient comfort, endurance and strength to accomplish activities of daily living? Can muscle group move joint independently through useful ranges of motion but with limitation by pain or easy fatigability or weakness? Can muscle group move joint only with assistance or with gravity eliminated? Is there no ability of muscle group to move joint even with gravity eliminated and joint passively moveable? Is any muscle contraction felt?
10. If joint function is affected:
    a. Using a goniometer, measure the <u>passive</u> and <u>active</u> range of motion, including movement against gravity and against strong resistance
    b. State to what extent (if any) and in which degrees (if possible) the range of motion or function is <u>additionally limited</u> by pain, fatigue, weakness, or lack of

endurance following repetitive use or during flare-ups. If more than one of these is present, state, if possible, which has the major functional impact.

D. **Diagnostic and Clinical Tests:**

1. If applicable, x-rays of joint(s) involved in two planes or anatomic area involved if not recorded in past (once taken, the x-rays do not need to be repeated).
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

EYE EXAMINATION

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Pain.
2. Duration and frequency of periods of incapacitation, and rest requirements.
3. Visual symptoms, including distorted or enlarged image, etc.
4. Current ophthalmologic treatment.
5. For malignant neoplasms, state type of treatment and last date. If treatment is current, describe.

C. **Physical Examination (Objective Findings):**

Address each of the following, **as applicable**, and fully describe current findings:

1. Visual Acuity:
    a. Examine each eye independently and record the refractive information indicated below.
    b. Use conventional lenses for correction unless the patient has keratoconus, is well adapted to contact lenses and wishes to wear them, and contact lenses result in best corrected visual acuity. In that case, use contact lenses to determine best corrected visual acuity.
    c. Use Snellen's test type or its equivalent.
    d. Carry out an examination with the pupils dilated unless contraindicated, and record the ophthalmic findings.
    e. For visual acuity worse than 5/200 in either or both eyes, report the distance in feet/inches (or meters/centimeters) from the face at which the veteran can count fingers/detect hand motion/read the largest line on the chart. If the veteran cannot detect hand motion or count fingers at any distance, state whether he or she has light perception.
    f. If keratoconus is present, state whether contact lenses are required or adequate correction is possible by other means.

		NEAR	**FAR**
RIGHT EYE	UNCORRECTED	_____	_____
RIGHT EYE	CORRECTED	_____	_____

		NEAR	**FAR**
LEFT EYE	UNCORRECTED	_____	_____
LEFT EYE	CORRECTED	_____	_____

2. Diplopia:
    a. Perform the measurement of muscle function using a Goldmann Perimeter Chart and chart the areas in which diplopia exists. Include the chart as part of the examination report to be sent to the regional office.
    b. If diplopia is present, state whether it is constant or intermittent, whether it is present at all distances or only for near or distant vision, and whether it is correctable by use of lenses or prisms.
    c. If diplopia is constant and not correctable, indicate which sectors of the visual field are affected and provide the Goldmann perimeter chart showing the actual areas of diplopia, according to the format below. Diplopia outside these areas should also be reported even though it is not considered disabling because it may be used in the evaluation of the underlying disease or injury.

CENTRAL 20 DEGREES _____

21 TO 30 DEGREES

DOWN

RIGHT LATERAL _____

LEFT LATERAL_____

UP

RIGHT LATERAL _____

LEFT LATERAL_____

31 TO 40 DEGREES

DOWN

RIGHT LATERAL _____

LEFT LATERAL_____

UP

RIGHT LATERAL _____

LEFT LATERAL_____

3. Visual Field Deficit:
    a. Chart any visual field defect using a Goldmann Perimeter Chart and include the chart as part of the examination report to be sent to the regional office.
    b. For an aphakic eye which cannot be fitted with contact lenses or intra-ocular implant, use the IV/4e test object. For all other cases, use the III/4e test object.
    c. If the examiner determines that charting with other test objects is indicated, those test results should be reported on a separate chart. All charts, along with an explanation of the need for using a different test object and an explanation of any discrepancies in results, should be included as part of the examination

report.

d. All scotomas should be plotted carefully in order to allow measurements to be made for adjustments in the calculation of visual field defects.

4. Details of eye disease or injury (including eyebrows, eyelashes, eyelids) other than loss of visual acuity, diplopia, or visual field defect:

D. **Diagnostic and Clinical Tests:** (Other than for visual acuity, diplopia, and visual fields, as described above.)

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis**:

Signature: Date:

Compensation and Pension Examination

AUDIO

Name: SSN:

Date of Exam: C-number:

Place of Exam:

Narrative: An examination of hearing impairment must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (specifically, the Maryland CNC *recording*) and a pure tone audiometry test in a sound isolated booth that meets American National Standards Institute standards (ANSI S3.1. 1991) for ambient noise. Measurements will be reported at the frequencies of 500, 1000, 2000, 3000, and 4000 Hz. The examination will include the following tests: Pure tone audiometry by air conduction at 250, 500, 1000, 2000, 3000, 4000, and 8000 Hz, and by bone conduction at 250, 500, 1000, 2000, 3000, and 4000 Hz, spondee thresholds, speech recognition using the recorded Maryland CNC Test, tympanometry and acoustic reflex tests, and, when necessary, Stenger tests. Bone conduction thresholds are measured when the air conduction thresholds are poorer than 15 dB HL. A modified Hughson-Westlake procedure will be used with appropriate masking. A Stenger must be administered whenever pure tone air conduction thresholds at 500, 1000, 2000, 3000, and 4000 Hz differ by 20 dB or more between the two ears. Maximum speech recognition will be reported with the 50 word VA approved recording of the Maryland CNC test. When speech recognition is 92% or less, a performance intensity function will be obtained with a starting presentation level 40 dB re SRT. If necessary, the starting level will be adjusted upward to obtain a level at least 5 dB above the threshold at 2000 Hz. The examination will be conducted without the use of hearing aids. Both ears must be examined for hearing impairment even if hearing loss in only one ear is at issue.

A. **Review of Medical Records:** Indicate whether the C-file was reviewed.

B. **Medical History (Subjective Complaints):**

Comment on:

1. Chief complaint.
2. Situation of greatest difficulty.
3. Pertinent service history.
4. History of military, occupational, and recreational noise exposure.
5. Tinnitus - If present, state:
    a. Date and circumstances of onset.
    b. Whether it is unilateral or bilateral.
    c. Whether it is recurrent (indicate frequency and duration).
    d. The most likely etiology of the tinnitus, and specifically, if hearing loss is present, whether the tinnitus is due to the same etiology (or causative factor) as the hearing loss.

C. **Physical Examination (Objective Findings):**

1. Measure puretone thresholds in decibels at the indicated frequencies (air conduction):

= = = = = = =RIGHT EAR= = = = = = = = = = = = = = = = LEFT EAR = = = = = = =

A*	B	C	D	E	**	A*	B	C	D	E	**
500	1000	2000	3000	4000	average	500	1000	2000	3000	4000	average

* The puretone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.

** The average of B, C, D, and E.

2. Speech Recognition Score: Maryland CNC word list

_____% right ear _____% left ear.

3. When only puretone results should be used to evaluate hearing loss, the examiner, who must be a state-licensed audiologist, should certify that language difficulties or other problems (specify what the problems are) make the combined use of puretone average and speech discrimination inappropriate.

D. **Diagnostic and Clinical Tests:**

1. Report middle ear status, confirm type of loss, and indicate need for medical follow-up. In cases where there is poor inter-test reliability and/or positive Stenger test results, obtain and report estimates of hearing thresholds using a combination of behavioral testing, Stenger interference levels, and electrophysiological tests.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. Summary of audiologic test results. Indicate type and degree of hearing loss for the frequency range from 500 to 4000 Hz. For type of loss, indicate whether it is normal, conductive, sensorineural, central, or mixed. For degree, indicate whether it is mild (26-40 HL), moderate (41-54 HL), moderately severe (55-69HL), severe (70-89 HL), or profound (90+HL).
[For VA purposes, impaired hearing is considered to be a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, and 4000 Hz is 40 dB HL or greater; or when the auditory thresholds for at least three of these frequencies are 26 dB HL or greater; or when speech recognition scores are less than 94%.]

2. Note whether, based on audiologic results, medical follow-up is needed for an ear or hearing problem, and whether there is a problem which, if treated, might cause a change in hearing threshold levels.

Signature: Date:

Compensation and Pension Examination

EAR DISEASE

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:** Indicate whether the C-file was reviewed.

B. **Medical History (Subjective Complaints):**

1. Describe history of hearing loss, tinnitus, vertigo, balance or gait problems, discharge, pain, pruritus. State onset and frequency and duration of each, if not constant.
2. Describe current or past treatment for ear conditions.
3. If a malignant neoplasm of the ear is or was present:

a. State date of confirmed diagnosis.

b. State date of the last surgical, X-ray, antineoplastic chemotherapy, radiation, or other therapeutic procedure.

c. State expected date treatment regimen is to be completed.

d. If treatment is already completed, provide date of last treatment.

e. If treatment is already completed, fully describe residuals.

C. **Physical Examination (Objective Findings):**

1. Conduct an external and otoscopic examination. Address each of the following and describe current findings, including abnormalities of size, shape, or form:

a. Auricle. Any deformity? If there is tissue loss, state whether it is one-third or more of auricle.

b. External canal - describe any edema, scaling, discharge.

c. Tympanic membrane.

d. The tympanum.

e. Mastoids. Discharge? Evidence of cholesteatoma?

f. State all conditions secondary to ear disease, such as disturbance of balance, upper respiratory disease, hearing loss, etc.

2. State whether an active ear disease is present.
3. Infections of the middle or inner ear. Is there suppuration? Effusion? Are aural polyps present?
4. For peripheral vestibular disorders, state the specific diagnosis and its basis, whether there is dizziness and how often, and whether a staggering gait occurs and how often.
5. For Meniere's syndrome, state the symptoms, including the frequency of attacks of vertigo and cerebellar gait. Is tinnitus present? If so, how frequently and what is its duration? Is there hearing loss? (See audio worksheet.)
6. Describe any complications of ear disease that are present.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

SENSE OF SMELL AND TASTE

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

C. **Physical Examination (Objective Findings):**

D. **Diagnostic and Clinical Tests:**

1. For sense of smell, test each side of nose separately. State results with the following substances recommended for testing:
    a. Coffee.
    b. Soap.
    c. Oil of lemon.
    d. Other (state substance).

2. For sense of taste
    a. Using electrogustometry if available, test for:
        (1) Sweet.
        (2) Sour.
        (3) Bitter.
        (4) Salt.

    b. State results with the following substances recommended for testing:
        (1) Sugar.
        (2) Diluted acetic acid.
        (3) Lemon or Orange.
        (4) Salt.

3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Provide:

1. State whether loss of sense of smell is partial or complete, and its basis.
2. State whether loss of sense of taste is partial or complete, and its basis.
3. If a psychiatric basis is suspected, a special psychiatric examination should be ordered.

Signature: Date:

Compensation and Pension Examination

INFECTIOUS, IMMUNE, AND NUTRITIONAL DISABILITIES

Name: SSN:

Date of Exam: C-number:

Place of Exam:

Narrative: Many infectious diseases, immune disorders, and nutritional deficiencies have acute phases at onset and accompanying recurrences but leave little or no residual disability beyond the acute phase. Other such conditions may have slow progression and show significant residual disability. The examiner must diligently search for residual disabilities upon which adjudication of the case may be made.

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:
1. Date of symptom onset.
2. Date of diagnosis.
3. Clinical manifestations.
4. Treatment (type, frequency, duration, response, side effects).
5. Disease activity (exacerbations and/or remissions)? If there were exacerbations, what was the state of the veteran's health between exacerbations? Frequency and duration of exacerbations.
6. Current symptoms

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:
1. Is the condition still present?
2. Current weight, nutrition. Any residuals of malnutrition, vitamin deficiency?
3. General appearance.
4. Describe findings of all organ systems involved. See appropriate examination worksheets - respiratory, joints, cardiovascular, etc.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

Note: If an infectious etiology is documented, specify the organism.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

HIV-RELATED ILLNESS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment On:

1. Recurrent opportunistic infections.
2. Recurrent constitutional symptoms.
3. Diarrhea.
4. Debility.
5. Progressive weight loss.
6. Remissions in any symptomatology.
7. Depression or memory loss.
8. Treatment - Is this an approved medication?
9. Describe the effects of the condition on the veteran's usual occupation and daily activities.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe:

1. Definitive diagnosis of AIDS. (Use CDC Definition.)
2. Secondary diseases affecting multiple body systems - describe.
3. HIV-related illnesses - describe.
4. Neoplasm related to HIV-related illness. Describe.
5. T4 cell counts.
6. Hairy cell leukoplakia.
7. Oral candidiasis.
8. Use of HIV-related medications.
9. Lymphadenopathy.

D. **Diagnostic and Clinical Tests:**

Provide:

1. T4 Cell counts.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

CHRONIC FATIGUE SYNDROME

Name: SSN:

Date of Exam: C-number:

Place of Exam:

Narrative: Chronic fatigue syndrome (CFS) is an illness characterized by debilitating fatigue and several flu-like symptoms. It may have both physical and psychiatric manifestations and closely resembles neurasthenia, neurocirculatory asthenia, fibrositis, or fibromyalgia.

For VA purposes, a diagnosis of CFS must meet both of the following criteria:

1. New onset of debilitating fatigue that is severe enough to reduce or impair average daily activity below 50 percent of the patient's pre-illness activity level for a period of 6 months, and
2. Other clinical conditions that may produce similar symptoms must be excluded by thorough evaluation, based on history, physical examination, and appropriate laboratory tests.

It must also meet six or more of the following ten criteria:

1. Describe in detail:
    a. Acute onset of the condition.
    b. Low grade fever.
    c. Nonexudative pharyngitis.
    d. Palpable or tender cervical or axillary lymph nodes.
    e. Generalized muscle aches or weakness.
    f. Fatigue following lasting 24 hours or longer after exercise.
    g. Headaches (of a type, severity or pattern that is different from headaches in the premorbid state.
    h. Migratory joint pains.
    i. Neuropsychologic symptoms.
    j. Sleep disturbance.

A. **Review of Medical Records:**

Comment on:

1. Date diagnosis established.
2. Does it meet the requirements outlined above?

B. **Medical History (Subjective Complaints):**

Comment on:

1. Estimate the amount of routine daily activities that are restricted due to CFS. Give specific examples.
2. If there are incapacitating episodes (requiring bed rest and treatment by a physician), what is their frequency and duration?.
3. Does the patient require continuous medication for CFS?

C. **Physical Examination (Objective Findings):**

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

NOSE, SINUS, LARYNX, AND PHARYNX

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Location and nature of the injury or disease.
2. Interference with breathing through nose.
3. Purulent discharge.
4. Dyspnea at rest or on exertion?
5. Treatments - type (surgery, medication, oxygen, respirator, etc.) frequency, duration, response, and side effects.
   respirators, etc., response, and side effects.
6. If speech impairment (ability to communicate by speech, ability to speak above a whisper, etc.).
7. For chronic sinusitis, indicate which sinuses are affected and whether pain and headaches are present. Describe severity and frequency.
8. If allergic attacks, frequency and baseline status between attacks.
9. Other symptoms noted.
10. Describe frequency and duration of periods of incapacitation (defined as requiring bedrest and treatment by a physician).

C. **Physical Examination (Objective Findings):**

Provide:

1. If there is nasal obstruction, indicate percent each nostril.
2. Sinusitis - Describe tenderness, purulent discharge, or crusting.

D. **Diagnostic and Clinical Tests:**

1. If there is stenosis of larynx, order FEV-1 with flow-volume loop.
2. If there is facial disfigurement, order color photographs.
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Comment on whether the disease primarily involves or originates from the nose, sinus, larynx, or pharynx.

Signature: Date:

Compensation and Pension Examination

RESPIRATORY (OBSTRUCTIVE, RESTRICTIVE, AND INTERSTITIAL)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Productive cough, sputum, hemoptysis, and/or anorexia.
2. Extent of dyspnea on exertion.
3. If veteran is asthmatic, report frequency of attacks and baseline functional status between attacks.
4. Treatment (type, frequency and duration including a need for oxygen), response, side effects.
5. Describe frequency and duration of any periods of incapacitation (defined as requiring bedrest and treatment by a physician).

C. **Physical Examination (Objective Findings):**

Address each of the following as appropriate to the condition being examined and fully describe current findings:

1. Presence of cor pulmonale, RVH or pulmonary hypertension.
2. Weight loss or gain.
3. For restrictive disease, describe condition underlying restrictive disease, e.g., kyphoscoliosis, pectus excavatum, etc., unless already of record.

D. **Diagnostic and Clinical Tests:**

Provide:

1. Pulmonary Function Tests (unless carried out within past six months and the report is either in the claims folder or will be attached to this examination report, e.g., PFT's were in VAMC records at your facility). Spirometric pulmonary function testing should include FVC, FEV-1, and the FEV-1/FVC ratio. Both pre- and post-bronchodilatation test results should be reported. If post-bronchodilatation testing is not conducted in a particular case, please provide an explanation of why not. A DLCO may or may not be done routinely as part of pulmonary function testing at a particular facility. If there is a disparity between the results of different tests, please indicate which tests are more likely to accurately reflect the severity of the condition.

   DLCO note: If the DLCO was not done as a routine part of pulmonary function testing, the examiner should use his or her judgment, based on the specific condition (e.g., whether it is obstructive, interstitial, etc.) and other available information about the condition, as to whether a DLCO test is needed, since it is not useful in all situations. If it may provide useful information about the severity of the condition, it should be requested and reviewed before the examination report is submitted. If the examiner determines that the DLCO test is not needed, a statement as to why not (e.g., there are decreased lung volumes that would not yield valid test results) should be included in the report. Such a statement could avoid a remand from BVA when the test is not done. However, in the case of a BVA remand in which the DLCO is requested, the DLCO MUST be done unless there is a medical contraindication.

2. Chest X-ray (if no recent results available).
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

PULMONARY TUBERCULOSIS AND MYCOBACTERIAL DISEASES

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Activity of pulmonary tuberculosis or other mycobacterial disease.
2. Date of inactivity if it is not active.
3. Identity of organism (if possible).

C. **Physical examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Extent of structural damage to lungs.
2. If patient was hospitalized for 6 months or more, what is the condition at the end of hospitalization?
3. If patient was hospitalized for 12 months or more, what is the condition at the end of hospitalization?

D. **Diagnostic and Clinical Tests:**

Provide:

1. Pulmonary Function Tests, if indicated. If performed, include the results in the examination report. The FEV-1, FVC, and FEV-1/FVC should be included. Both pre- and post-bronchodilatation pulmonary function test results should be reported. If post-bronchodilatation testing is not conducted in a particular case, please provide an explanation of why not. A DLCO may or may not be done routinely as part of pulmonary function testing at a particular facility. If there is a disparity between the results of different tests, please indicate which tests are more likely to accurately reflect the severity of the condition.

   DLCO note: If the DLCO was not done as a routine part of pulmonary function testing, the examiner should use his or her judgment, based on the specific condition (e.g., whether it is obstructive, interstitial, etc.) and other available information about the condition, as to whether a DLCO test is needed, since it is not useful in all situations. If it may provide useful information about the severity of the condition, it should be requested and reviewed before the examination report is submitted. If the examiner determines that the DLCO test is not needed, a statement as to why not (e.g., there are decreased lung volumes that would not yield valid test results) should be included in the report. Such a statement could avoid a remand from BVA when the test is not done. However, in the case of a BVA remand in which the DLCO is requested, the DLCO MUST be done unless there is a medical contraindication.

E. **Diagnosis:**

1. In reactivated cases, is this reactivation of the old disease or a separate and distinct new infection?

Additional note to the examiner:

In all claims, if the disease is inactive and if the inactivity was confirmed at a non-VA facility, obtain the name and mailing address of the facility from the veteran so that the Regional Office may request the report.

Signature: Date:

Compensation and Pension Examination

RESPIRATORY DISEASES, MISCELLANEOUS
(PVD, Neoplasms, Bacterial Infections,
Mycotic Lung Disease, Sarcoidosis, and Sleep Apnea)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Fever and/or night sweats.
2. Weight loss or gain.
3. Daytime hypersomnolence.
4. Hemoptysis.
5. Describe current treatment such as anticoagulant, tracheostomy, CPAP, oxygen, or antimicrobial therapy.
6. If malignant disease, state initial treatment date, site of original tumor, type of tumor, types of treatment used, and date treatment is expected to end. If treatment has been completed, state date treatment was completed.

C. **Physical Examination (Objective Findings):**

Address each of the following as appropriate to the condition being examined and fully describe current findings:

1. Pulmonary Hypertension, RVH, cor pulmonale, or congestive heart failure.
2. Residuals of pulmonary embolism.
3. Respiratory Failure.
4. Evidence of chronic pulmonary thromboembolism.
5. If ankylosing spondylitis, is there restriction of the chest excursion and dyspnea on minimal exertion?
6. Describe all residuals of malignancy including those due to treatment.

D. **Diagnostic and Clinical Tests:**

1. Pulmonary Function Tests, if indicated. The FEV-1, FVC, and FEV-1/FVC should be included. Both pre- and post-bronchodilatation pulmonary function test results should be reported. If post-bronchodilatation testing is not conducted in a particular case, please provide an explanation of why not. A DLCO may or may not be done routinely as part of pulmonary function testing at a particular facility. If there is a disparity between the results of different tests, please indicate which tests are more likely to accurately reflect the severity of the condition.

   DLCO note: If the DLCO was not done as a routine part of pulmonary function testing, the examiner should use his or her judgment, based on the specific condition (e.g., whether it is obstructive, interstitial, etc.) and other available information about the condition, as to whether a DLCO test is needed. If it may provide useful information about the severity of the condition, it should be requested and reviewed before the examination report is submitted. If the examiner determines that the DLCO test is not needed, a statement as to why not (e.g., there are decreased lung volumes that would not yield valid test results) should be included in the report. Such a statement could avoid a remand from BVA when the test is not done. However, in the case of a BVA remand in which the DLCO is requested, the DLCO MUST be done unless there is a medical contraindication.

2. If sleep apnea is suspected, order Sleep Studies.
3. Chest X-ray if necessary to document sarcoidosis or other parenchymal disease.
4. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

HEART

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Past history - describe onset of disorder and frequency of cardiac symptoms, including angina, dyspnea, fatigue, dizziness, and syncope. Record dates and severity of episodes of acute cardiac illness, including myocardial infarction, congestive heart failure, and acute rheumatic heart disease. Describe all cardiac surgery, including coronary artery bypass, valvular surgery, cardiac transplant, and angioplasty.
2. Current treatment - type, dosage, response, and side effects.
3. With the exceptions given below, examinations for valvular heart disease, endocarditis, pericarditis, pericardial adhesions, syphilitic heart disease,, arteriosclerotic heart disease, myocardial infarction, hypertensive heart disease, heart valve replacement, coronary bypass surgery, cardiac transplantation, and cardiomyopathy, require the examiner to provide the METs level, determined by exercise testing, at which symptoms of dyspnea, fatigue, angina, dizziness, or syncope result.
4. Exercise testing is not required for the above listed conditions in the following circumstances:
    a. If exercise testing is medically contraindicated:
        1) In that case, provide the medical reason exercise testing cannot be conducted, and
        2) Provide an estimate of the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing, or shoveling snow) that results in dyspnea, fatigue, angina, dizziness, or syncope.
    b. If left ventricular dysfunction is present, and the ejection fraction is 50 percent or less.
    c. If there is chronic congestive heart failure or there has been more than one episode of acute congestive heart failure in the past year.
    d. With valvular heart disease—during active infection with valvular heart damage and for three months following cessation of therapy for the active infection.
    e. With endocarditis—for three months following cessation of therapy for active infection with cardiac involvement.
    f. With pericarditis—for three months following cessation of therapy for active infection with cardiac involvement.
    g. With myocardial infarction—for three months following myocardial infarction.
    h. With valve replacement—for six months following date of hospital admission for valve replacement.
    i. With coronary bypass surgery—for three months following hospital admission for surgery.
    j. For cardiac transplantation—for indefinite period from date of hospital admission for cardiac transplantation.
    k. If an exercise test has been done within the past year, the results are of record, and there is no indication that there has been a change in the cardiac status of the veteran since.
5. For hyperthyroid heart disease, if atrial fibrillation is present, use arrhythmia worksheet. Also use endocrine worksheet if examining for hyperthyroidism.
6. Describe the effects of the condition on the veteran's usual occupation and daily activities.
7. Even when special examinations and tests (e.g., exercise testing) are not required

under the worksheet guidelines, they may be requested or conducted at the discretion of the examiner, when the examiner believes that the available information does not fully reflect the severity of the veteran's cardiovascular disability.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Heart size and method of determination, heart rhythm and rate, heart sounds, blood pressure.
2. Evidence of congestive heart failure - rales, edema, liver enlargement, etc.

D. **Diagnostic and Clinical Tests:**

1. Chest X-ray, EKG, exercise stress test, echocardiogram, Holter monitor, thallium study, angiography, etc., as appropriate, and as required or indicated.
2. Include results of all diagnostic and clinical tests conducted in the examination report, including status of left ventricular function, if measured.
3. Valvular heart disease and endocarditis require documentation of diagnosis by physical findings and either echocardiogram, Doppler echocardiogram, or cardiac catheterization, if not already of record.
4. Other types of heart disease must be documented by appropriate objective diagnostic tests.

E. **Diagnosis and Opinion:**

1. Type of heart disease and etiology, if known.
2. Type of surgery, if any, and results.
3. If the veteran is service-connected for rheumatic heart disease and later develops non-service-connected arteriosclerotic heart disease, state, if possible, which cardiac findings can be attributed to each condition. If it is not possible to separate the signs and symptoms of one from the other, so state, and explain.

Signature: Date:

Compensation and Pension Examination

ARRHYTHMIAS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

1. Type of arrhythmia, onset of disorder, frequency and duration of attacks. Attacks confirmed by EKG or Holter monitor?.
2. Pacemaker present? If so, when was it inserted, effectiveness, side effects?
3. Other treatment? If so, type, effectiveness, side effects?
4. For sustained ventricular arrhythmias, atrioventricular block, and implantable cardiac pacemakers (if ventricular arrhythmia or atrioventricular block was the reason for the pacemaker), the examiner must provide the METs level, determined by exercise testing, at which symptoms of dyspnea, fatigue, angina, dizziness, or syncope result.
5. Exercise testing is not required for the above listed conditions in the following circumstances:
    a. If exercise testing is medically contraindicated:
        1) In that case, provide the medical reason exercise testing cannot be conducted, and
        2) Provide an estimate of the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing, or shoveling snow) that results in dyspnea, fatigue, angina, dizziness, or syncope.
    b. For sustained ventricular arrhythmia—from date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia or for ventricular aneurysmectomy, and for six months following discharge.
    c. With an automatic implantable Cardioverter-Defibrillator (AICD) in place.
    d. For two months following hospital admission for implantation or reimplantation of an implantable cardiac pacemaker.
    e. If an exercise test has been done within the past year, the results are of record, and there is no indication that there has been a change in the cardiac status of the veteran since.

6. For implantable cardiac pacemakers—if supraventricular arrhythmia was the reason for the pacemaker—describe any attacks of atrial fibrillation or other symptoms.
7. Describe the effects of the condition on the veteran's usual occupation and daily activities.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Heart size and method of determination, heart rate and rhythm, blood pressure.
2. Status of cardiac function - evidence of congestive heart failure.
3. Cardiac arrhythmia - type. Confirmed by EKG or Holter monitor?

D **Diagnostic and Clinical Tests:**

1. EKG.
2. Holter monitor, other tests as indicated.
3. Chest X-ray, exercise stress test, echocardiogram, Holter monitor, thallium study, angiography, etc., as appropriate, and as required or indicated.

4. Include results of all diagnostic and clinical tests conducted in the examination report, including status of left ventricular function, if measured.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

ARTERIES, VEINS, AND MISCELLANEOUS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

For all conditions, comment on:

1. Course, including onset of disorder, and any treatment, including surgery (type and when carried out).
2. Symptoms.
3. Is exercise and exertion precluded by the condition?
4. Current treatment - type, effectiveness, side effects.
5. If surgery has been done, report effectiveness and any residual or recurrent symptoms.
6. Describe the effects of the condition on the veteran's usual occupation and daily activities.

For aortic aneurysm, aneurysm of any large artery, aneurysm of any small artery, arteriovenous fistula, arteriosclerosis obliterans and thromboangiitis obliterans, additionally comment on:

1. If lower extremities are affected, is there claudication, and, if so, after how many yards of walking on level ground at 2 miles per hour does it develop?
2. Is there pain at rest?

For Raynaud's phenomenon, angioneurotic edema, and erythromelalgia, additionally comment on:

1. Describe a characteristic attack.
2. Record the frequency, duration, and severity of characteristic attacks.
3. Describe which parts of the body are affected. For angioneurotic edema, state whether laryngeal edema occurs and how frequently.
4. What is the current treatment - type, dose, effectiveness, side effects?
5. Describe the effects of the condition on the veteran's usual occupation and daily activities.

For Varicose veins and Post-phlebitic syndrome of any etiology, additionally comment on:

1. Describe symptoms, noting particularly whether aching, fatigue, or abnormal sensations are present in the leg at rest or after prolonged standing or walking.
2. Are symptoms or edema relieved by elevation of the extremity, compression hosiery, or other measures?
3. What is the current treatment - type, dose, effectiveness, side effects.
4. What are the effects of the condition on the veteran's usual occupation and daily activities?

For soft tissue sarcoma or other malignant neoplasms of vascular origin:

1. Record date of diagnosis and pathologic diagnosis.
2. Record type and dates of treatment. If treatment has been completed, state date of last treatment.
3. Describe current symptoms. If treatment has been completed, describe residual or recurrent symptoms.
4. What are the effects of the condition on the veteran's usual occupation and daily activities?

C. **Physical Examination (Objective Findings):**

1. For aortic aneurysm, aneurysm of any large artery, aneurysm of any small artery, or arteriovenous fistula:
    a. State size of aneurysm, cardiac status, including heart size and rate, pulse pressure, and whether there is evidence of high output failure.
    b. If extremities are affected, describe temperature and color, pulses, trophic changes, ulcers (deep or superficial?), edema, dermatitis, cellulitis.
    c. If lower extremities are affected, record ankle/brachial index (using Doppler).
    d. If surgery has been carried out, describe residual findings, using appropriate worksheet for the affected body system or organ.
2. For arteriosclerosis obliterans and thromboangiitis obliterans:
    a. Describe each affected extremity separately.
    b. Record ankle/brachial index (using Doppler).
    c. Describe temperature and color of extremities, pulses, trophic changes, ulcers (deep or superficial?).
    d. If surgery has been carried out, describe any residuals or side effects of surgery.
3. For Raynaud's phenomenon, angioneurotic edema, and erythromelalgia:
    a. Describe ulcers, autoamputations, and any other current findings.
4. For Varicose veins and Post-phlebitic syndrome of any etiology:
    a. Describe any visible or palpable varicose veins.
    b. Describe extent of any ulcers, edema, stasis pigmentation, and eczema. If edema is present, is it boardlike? Is it persistent?
    c. Describe each affected extremity separately.
5. For soft tissue sarcoma or other malignant neoplasms of vascular origin:
    a. Describe all current findings, whether pre- or post-treatment, including any residuals of treatment. Use other worksheets, if necessary, specific to the affected body system or organs.

D. **Diagnostic and Clinical Tests:**

1. X-rays, Doppler vascular studies, angiogram, etc., as appropriate, and if indicated.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

HYPERTENSION

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Date of diagnosis.
2. Symptoms, if any.
3. Treatment - type, dosage, side effects.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Blood pressure - If the diagnosis of hypertension has not been previously established, readings must be taken two or more times on at least three different days. If hypertension has been previously diagnosed, take three blood pressure readings on the day of examination.
2. Cardiac status - size, function. If there is evidence of hypertensive heart disease, use Heart Worksheet.
3. If arteriosclerotic complications of hypertension are present, use worksheet for the specific condition(s) found.

D. **Diagnostic and Clinical Tests:**

1. X-rays or other tests, as indicated.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

MOUTH, LIPS, AND TONGUE

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Disfigurement - if present, order color photographs.
2. Interference with mastication.
3. Interference with speech - state extent.
4. Absence of all or part of tongue - describe.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

ESOPHAGUS AND HIATAL HERNIA

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Dysphagia - for solids, liquids (frequency and extent).
2. Pyrosis, epigastric or other pain, including associated substernal or arm pain (frequency and severity).
3. Hematemesis or melena (describe any episodes).
4. Reflux or regurgitation (frequency); for regurgitation, contents.
5. Nausea, vomiting (frequency, precipitants).
6. Current treatment - if dilatation, give frequency.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. General state of health, anemia.
2. Nutrition, weight gain or loss.

D. **Diagnostic and Clinical Tests:**

1. X-ray or endoscopic confirmation of obstruction, abnormal motility, esophagitis, reflux, etc.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. With obstruction or spasm, amenable to dilatation?

Signature: Date:

Compensation and Pension Examination

INTESTINES (LARGE AND SMALL)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Weight gain or loss.
2. Nausea and/or vomiting.
3. Constipation, diarrhea (frequency, severity, duration, and episodic or not?).
4. For fistula - frequency, duration, and amount of fecal discharge.

.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Malnutrition, anemia, other evidence of debility.
2. Abdominal pain - location, type, frequency, and duration.
3. Current treatment - type, duration, response, and side effects.
4. For fistula - location.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

LIVER, GALL BLADDER, AND PANCREAS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:** This may be of particular importance when hepatitis C (HCV) or chronic liver disease is claimed as related to service.

B. **Medical History (Subjective Complaints):**
Comment on:

1. Vomiting, hematemesis, or melena.
2. Current treatment–type (medication, diet, enzymes, etc.), duration, response, side effects.
3. Episodes of colic or other abdominal pain, fever, distention, nausea, or vomiting. Describe the duration, frequency, severity, treatment, and response to treatment.
4. Fatigue, weakness, depression, or anxiety, and their severity.
5. Past biliary tract surgery.
6. When chronic liver disease is claimed:
    - Record history of and dates for any risk factors for liver disease, including transfusion or organ transplant before 1992, hemodialysis, tattoo, body piercing, intravenous (or intranasal cocaine) drug use, occupational blood exposure or other percutaneous blood exposure, high-risk sexual activity, etc. Intramuscular gamma globulin shots may be claimed as a risk factor for hepatitis C, but, to date, no transmission of HCV by this means has been shown.
    - Describe current symptoms of liver disease and onset of symptoms.
    - Provide history of any hepatitis in service and discuss its relationship to current liver disease.
    - Provide history of alcohol use/abuse, both current and past.

C. **Physical Examination (Objective Findings):**
Address each of the following as appropriate, and fully describe current findings:

1. Ascites.
2. Weight gain or loss, steatorrhea, malabsorption, malnutrition.
3. Hematemesis or melena (describe any episodes).
4. Pain or tenderness–location, type, precipitating factors.
5. Liver size, superficial abdominal veins.
6. Muscle strength and wasting.
7. Any other signs of liver disease, e.g., palmar erythema, spider angiomata, etc.

D. **Diagnostic and Clinical Tests:**

1. For esophageal varices, X-ray, endoscopy, etc.
2. For adhesions, X-ray to show partial obstruction, delayed motility.
3. For gall bladder disease, X-ray or other objective confirmation.
4. For liver disease:
    - Liver function tests (albumin, prothrombin time, bilirubin, AST, ALT, WBC, platelets).
    - Serologic tests for hepatitis (HBsAg, anti-HCV (EIA or ELISA) anti-HBc, ferritin, alpha-fetoprotein); and liver imaging (ultrasound or abdominal CT scan), as appropriate.
    - If hepatitis C is the suspected diagnosis, a positive EIA (enzyme immunoassay) test for hepatitis C should be confirmed by a RIBA (recombinant immunoblot assay) test **OR** by an HCV RNA test, either qualitative or quantitative. The diagnosis of hepatitis C infection should not be made unless such test results are in the record and support the diagnosis. A positive EIA test alone is not sufficient to

establish the diagnosis, nor is a liver biopsy with a report that indicates it is "consistent with" hepatitis C infection.

- With a diagnosis of hepatitis, name the specific type (A, B, C, or other), and for hepatitis B and C, provide an opinion as to which risk factor is the most likely cause. Support the opinion by discussing all risk factors in the individual and the rationale for your opinion. If you can not determine which risk factor is the likely cause, state that there is no risk factor that is more likely than another to be the cause, and explain.
- With a diagnosis of cirrhosis, chronic hepatitis, liver malignancy, or other chronic liver disease, state the most likely etiology and the basis for your opinion. Address the relationship of the disease to active service, including any hepatitis or hepatitis risk factor that occurred in service. If you cannot determine the most likely etiology, cannot determine whether it is more likely than not that one of multiple risk factors is the cause, or cannot determine whether it is at least as likely as not that the liver disease is related to service, so state and explain.

5. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

DIGESTIVE CONDITIONS, MISCELLANEOUS
(Tuberculous Peritonitis, Inguinal Hernia, Ventral Hernia, Femoral Hernia, Visceroptosis, and Benign and Malignant New Growths)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

1. Describe all hernia surgery and results.
2. For malignancy, state type of treatment, dates of treatment, including last date of treatment if it has ended.
3. For peritoneal tuberculosis, state date of diagnosis, treatment, and date on which inactivity was established.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. For inguinal or ventral hernia, state whether reducible, how well supported by truss or belt, and whether irremediable or inoperable.
2. For ventral hernia, state size of hernia, extent of diastasis of recti muscles, status of muscles and fascia of abdominal wall.
3. All residuals of malignancy, including residuals from treatment.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

RECTUM AND ANUS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Degree of sphincter control.
2. Extent and frequency of fecal leakage or involuntary bowel movements- is a pad needed?
3. Bleeding or thrombosis of hemorrhoids - frequency and extent.
4. Current treatment.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Colostomy.
2. Evidence of fecal leakage.
3. Size of lumen - rectum and anus.
4. Signs of anemia.
5. Fissures.
6. If hemorrhoids - location, size, and if thrombosed.
7. Evidence of bleeding.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

STOMACH, DUODENUM, AND PERITONEAL ADHESIONS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Vomiting.
2. Hematemesis or melena (describe any episodes).
3. Treatment - type, duration, response, side effects.
4. Circulatory disturbance after meals, hypoglycemic reactions (state time of onset in relation to meals, frequency).
5. Diarrhea, constipation.
6. Episodes of colic, distention, nausea, and/or vomiting - frequency, duration, and severity.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Specific site of any ulcer disease.
2. Weight gain or loss.
3. Signs of anemia.
4. Pain or tenderness - location, type, precipitating factors.

D. **Diagnostic and Clinical Tests:**

1. For gastritis, endoscopic evidence - describe hemorrhage, ulcerated or eroded areas.
2. For adhesions, X-ray to show partial obstruction, delayed motility.
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

GENITOURINARY EXAMINATION

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Lethargy, weakness, anorexia, weight loss or gain.
2. Frequency (day or night, indicate voiding intervals), hesitancy, stream, dysuria.
3. Incontinence - if present, describe required frequency of absorbent material and whether an appliance is needed.
4. Provide details of any history of:
    a. Surgery on any part of the urinary tract. Residuals? Impotence?
    b. Recurrent urinary tract infections.
    c. Renal colic or bladder stones.
    d. Acute nephritis.
    e. Hospitalization for urinary tract disease, if so, how many in the past year?
    f. Treatment for malignancy, including type and date of last treatment.
5. Treatments.
    a. Is catheterization needed? Intermittent or continuous?
    b. Frequency of dilations?
    c. Drainage procedures.
    d. Diet therapy - specify.
    e. Medications.
    f. Frequency per year of invasive and noninvasive procedures.
6. Describe the effects of the condition(s) on the veteran's usual occupation and daily activities.

For Male Loss of Use of a Creative Organ

Comment on:

1. Trauma/surgery affecting penis/testicles (e.g. vasectomy?)
2. Local and/or systemic diseases affecting sexual function.
    a. Endocrine.
    b. Neurologic.
    c. Infections.
    d. Vascular.
    e. Psychological.
3. Symptoms: Vaginal penetration with ejaculation possible?
4. Past treatment:
    a. Medications, injections, implants, pump, counseling
    b. Effectiveness in allowing intercourse.

C. **Physical Examination (Objective Findings):**

Address each of the following, as appropriate, to the condition being examined and fully describe current findings:

1. Blood pressure, cardiovascular examination, if indicated, describe edema, to include

persistence.
2. If on dialysis, type, where done, and how often?
3. Inspection and palpation of penis, testicles, epididymis, and spermatic cord. If there is penis deformity, state whether there is loss of erectile power. Inspection of anus and digital exam of rectal walls, prostate, and seminal vesicles.
4. Fistula.
5. Specific residuals of genitourinary disease, including post-treatment residuals of malignancy.
6. Testicular atrophy - size and consistency.
7. Sensation and reflexes
8. Peripheral pulses

D. **Diagnostic and Clinical Tests:**

1. CBC.
2. UA.
3. Creatinine, BUN, albumin, electrolytes.
4. Uroflowmetry, if indicated.
5. Measurement of post-void residual, if indicated.
6. Semen analysis, including sperm count and interpretation of results, if applicable.
7. Endocrine evaluation (glucose, TSH, testosterone, LH, FSH, prolactin), if applicable.
8. Psychiatric evaluation, if applicable.
9. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

GYNECOLOGICAL CONDITIONS AND DISORDERS OF THE BREAST

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Provide:

1. Date of onset of symptoms.
2. Describe symptoms, e.g., abnormal bleeding, vaginal discharge, fever, pain, bowel or bladder symptoms, etc.
3. Treatments:
    a. Detail all breast and pelvic surgery.
    b. If a malignant process has been identified, provide:
        (1) Date of confirmed diagnosis.
        (2) Date of the last surgical, X-ray, antineoplastic chemotherapy, radiation, or other therapeutic procedure.
        (3) Expected date treatment regimen is to be completed.
        (4) If already completed, provide date.
        (5) Fully describe residuals.
    c. Detail hormonal and other medications and whether continuous medication is required, response, and side effects.
4. Include complete menstrual history, pregnancy history, and urinary tract history.

C. **Physical Examination (Objective Findings):**

Provide a full gynecological and breast examination (*unless only a particular condition or portion of the examination is requested*).

Address each of the following and fully describe current findings:

1. Uterus.
    a. If post operative, state extent of surgery.
    b. If prolapse is present, is it through the introitus?
    c. If displaced, are there adhesions and/or menstrual disturbances.
2. If rectovaginal fistula is present, describe extent and frequency of leakage and whether a pad is required.
3. If urethrovaginal fistula is present, describe whether absorbent material is required and how often it must be changed.
4. If rectocele, cystocele, or perineal relaxation is present, is it due to pregnancy?
5. Breasts.

    If post-operative, Identify the type of surgery using the following definitions:

    a. Radical mastectomy - removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament.
    b. Modified radical mastectomy - removal of the entire breast and axillary lymph nodes (in continuity with the breast). Pectoral muscles are left intact.
    c. Simple (or total) mastectomy - removal of all the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact.
    d. Wide local incision - includes partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy. This means removal of a

portion of the breast tissue.

e. Describe any alteration of size and form.

D. **Diagnostic and Clinical Tests:**

1. CBC.
2. Urinalysis.
3. Laparoscopy is required to establish diagnosis of endometriosis and to confirm bowel or bladder involvement.
4. Ultrasound, mammography, if indicated.
5. Pap smear (if none within past year).
6. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

HEMIC DISORDERS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Frequency and duration of crisis if sickle cell disease.
2. Fatigability and/or weakness? (Is light manual labor precluded?)
3. Headaches?
4. History of infections? If yes, frequency and response to therapy?
5. Shortness of breath? If yes, with what degree of exertion?
6. Chest pain? Symptoms of claudication?
7. History and frequency of transfusions, phlebotomy, bone marrow transplant, myelo-suppressant therapy.
8. Symptoms of other end organ pathology?
9. Disease activity (exacerbations/remission)? If there were exacerbations, what was the state of the veteran's health between exacerbations?
10. Current and past treatment history including date and type of last treatment?
11. Syncope, lightheadedness.

C. **Physical Examination (Objective Findings):**

Address each of the following as appropriate to the condition being examined and fully describe current findings:

1. Swelling of hands and/or feet (edema)?
2. Presence of pallor (nail beds, mucosal surfaces, and skin)?
3. Any other significant physical exam findings?
4. Residuals of bone or other vascular infarction.
5. Congestive heart failure?

D. **Diagnostic and Clinical Tests:**

1. Hemoglobin level, platelet count, CBC.
2. X-rays of bones or joints as indicated.
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. Is the disease active?

Signature: Date:

Compensation and Pension Examination

LYMPHATIC DISORDERS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Disease activity (exacerbations/remission)? If there were exacerbations, what was the state of the veteran's health between exacerbations?
2. Current and past treatment history including date and type of last treatment, response, side effects.
3. If malignant neoplasm need date of diagnosis, date of treatment, or if treatment stopped when did it end.
4. Location of disease.
5. Current symptoms.

C. **Physical Examination (Objective Findings):**

Describe the residuals of each body system affected.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

SCARS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

1. Type of injury or infection causing the wound or scar, its date, the treatment used and the response to such treatment.
2. Current symptoms.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings (for each scar):

1. Location, measurements (cm. x cm.), and shape of each scar.
2. Tenderness.
3. Adherence.
4. Texture.
5. Ulceration or breakdown of skin.
6. Elevation or depression of scar.
7. Extent of underlying tissue loss.
8. Inflammation, edema, or keloid formation.
9. Color of scar compared to normal areas of skin.
10. Disfigurement.
11. For each burn scar, state if due to a 2nd or 3rd degree burn.
12. Limitation of function by scar.
13. An attachment is provided in the Handout of Instructions for Compensation and Pension Examinations for plotting the location of scars.

D. **Diagnostic and Clinical Tests:**

1. With disfigurement or disfiguring scar of head, face, or neck, submit color photographs.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

SKIN DISEASES (Other Than Scars)

Name: **SSN:**

Date of Exam: **C-number:**

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Onset of disease and course - intermittent, constant.
2. Current treatment - include side effects.
3. Symptoms - pruritus, pain, etc.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Extent of disease - specify what exposed areas are involved and how large they are.
2. Ulceration, exfoliation, or crusting.
3. Associated systemic or nervous manifestations.

D. **Diagnostic and Clinical Tests:**

1. Biopsy, scrapings if indicated.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. Take color photographs if disfigurement or disfiguring scars are present.

Signature: Date:

Compensation and Pension Examination

ENDOCRINE DISEASES, MISCELLANEOUS
(Benign and Malignant Neoplasms, Hyperpituitarism, Hyperaldosteronism, and Pheochromocytoma)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B**. Medical History (Subjective Complaints):**

Comment on:

1. Date of diagnosis and how established.
2. Fatigability.
3. Headaches.
4. Changes in vision.
5. Neurologic, cardiovascular, or gastrointestinal symptoms.
6. Treatments (surgery, medications, hormones), including dose, frequency, response, side effects. For malignancy, provide date of completion of treatment for malignancy.
7. Weight gain or loss.
8. Excessive thirst, frequency of urination.
9. Describe the effects of the condition(s) on the veteran's usual occupation and daily activities.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. For hypoparathyroidism, thyroid surgery scar?
2. For diabetes insipidus, signs of dehydration?
3. For Addison's disease, muscle strength, blood pressure, skin pigmentary changes. Number of crises (with peripheral vascular collapse) or episodes (less acute and severe than crisis - no peripheral vascular collapse).
4. For pluriglandular syndromes, see examinations for glands affected.
5. Describe all residuals of benign or malignant neoplasm, including those related to treatment.
6. Is the disease active or in remission?
7. For hyperparathyroidism, history of kidney stones. History of demineralization of skeleton.

D. **Diagnostic and Clinical Tests:**

Provide, as appropriate:

1. Blood and urinary calcium.
2. X-ray of bones to confirm decalcification.
3. Glucose tolerance test, if necessary.
4. Antidiuretic hormone level.
5. Serum and urine electrolytes.
6. Urine specific gravity.
7. Serum cortisol.
8. Serum creatinine.
9. Serum glucose.
10. ACTH test.

11. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

THYROID AND PARATHYROID DISEASES

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Date diagnosis established.
2. Fatigability.
3. Mental assessment.
4. Neurologic, cardiovascular, or gastrointestinal symptoms.
5. Treatments (surgery, medications, hormones), including dose, frequency, response, side effects. For C-cell hyperplasia, provide date of completion of any treatment for malignancy.
6. Symptoms due to pressure (on larynx, esophagus, etc.).
7. Cold or heat intolerance.
8. Constipation.
9. Weight gain or loss.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Thyroid size.
2. Pulse and blood pressure.
3. Eye and vision abnormalities.
4. Muscle strength.
5. Tremor.
6. Myxedema.
7. All other residuals of thyroid disease or its treatment.

D. **Diagnostic and Clinical Tests:**

Provide:

1. T4, T3, TSH, and/or other thyroid function tests, if needed.
2. If thyroidectomy scar is disfiguring, order color photograph.
3. Thyroid scan, if indicated.
4. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Comment on:

1. Is the disease active or in remission?

Signature: Date:

Compensation and Pension Examination

CUSHING'S SYNDROME

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Date diagnosis established.
2. Weakness.
3. Etiology ? Iatrogenic?
4. Treatments (surgery, medication, etc.), dose, frequency, response, side effects.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Muscle strength.
2. Vascular fragility.
3. Gastrointestinal.
4. Blood Pressure.
5. Striae.
6. Weight gain or loss.
7. Moonface.
8. Glucose metabolism.
9. After control, describe adrenal insufficiency, cardiovascular, psychiatric, skin, or skeletal complications or residuals.

D. **Diagnostic and Clinical Tests:**

Provide:

1. CT of brain or X-ray of sella turcica.
2. Serum and urine cortisol levels.
3. High and low dose dexamethasone suppression test.
4. X-rays if osteoporosis suspected.
5. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Comment on:

1. Is the disease active or in remission?

Signature: Date:

Compensation and Pension Examination

ACROMEGALY

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Date diagnosis established.
2. Joint pains.
3. Changes in vision.
4. Headaches (severity and frequency).
5. Cardiac symptoms.
6. Change in shoe, glove, or hat size.
7. Symptoms of glucose intolerance.
8. Treatments.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Arthropathy.
2. Vascular fragility.
3. Evidence of increased intracranial pressure.
4. Size of acral parts, long bones.
5. Visual impairment, including visual fields.

D. **Diagnostic and Clinical Tests:**

Provide:

1. CT of brain or X-ray of sella turcica.
2. Glucose tolerance test.
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Comment on:

1. Is the disease active or in remission?

Signature: Date:

Compensation and Pension Examination

DIABETES MELLITUS

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Age of onset.
2. Frequency of ketoacidosis or hypoglycemic reactions (hospitalization required?).
3. Restricted diet, weight loss or gain since last exam.
4. Describe any restriction of activities.
5. Visual problems.
6. Vascular or cardiac symptoms.
7. Neurologic symptoms.
8. Treatment - oral hypoglycemic, insulin (frequency of injections).
9. Frequency of visits to diabetic care provider.
10. Other symptoms, such as anal pruritus, loss of strength.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Blood pressure, other cardiovascular findings, including status of peripheral vessels.
2. Neurologic examination.
3. Eye examination.
4. Skin examination.
5. Examination of extremities, including feet.
6. State if the veteran has bladder or bowel functional impairment. If present, state whether partial or total, intermittent or constant and what measures are taken as a result of the impairment.

D. **Diagnostic and Clinical Tests:**

Provide:

1. Renal function tests, including 24 hour urine test for protein if renal involvement is uncertain.
2. Blood sugar.
3. Urinalysis.
4. Glucose tolerance test, if necessary to establish the diagnosis.
5. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Comment on:

1. All complications noted - visual, cardiac, vascular, nephrologic, neurologic (including both peripheral neuropathy and cerebral effects), amputations. See examination worksheets for the conditions found.

Signature: Date:

Compensation and Pension Examination

BRAIN AND SPINAL CORD

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. If flare-ups exist, describe precipitating factors, aggravating factors, alleviating factors, alleviating medications, frequency, severity, duration and whether the flare-ups include pain, weakness, fatigue or functional loss.
2. Current treatment, response, and side effects.
3. State whether condition has stabilized.
4. Seizures - type, frequency.
5. Headache, dizziness, etc.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. If a tumor is or was present, note location, type, and whether or not it is malignant. If a malignancy is present but is now cured or in remission, report the date of last surgery, radiation therapy, chemotherapy or other treatment.
2. Describe in detail the motor and sensory impairment of all affected nerves.
3. Describe in detail any functional impairment of the peripheral and autonomic systems.
4. A detailed assessment of each affected joint is required.
    a. Using a goniometer, measure the passive and active range of motion, including movement against gravity and against strong resistance.
    b. If the joint is painful on motion, state at what point in the range of motion pain begins and ends.
    c. State to what extent, if any, the range of motion or function is additionally limited by pain, fatigue, weakness, or lack of endurance. If more than one of these is present, state, if possible, which has the major functional impact.
5. Describe any psychiatric manifestations in detail - see worksheets for mental disorders.
6. Eye examination.
7. State if the veteran has bladder or bowel functional impairment. If present, state whether partial or total, intermittent or constant and what measures are taken as a result of the impairment.
8. State if the veteran is capable of managing his or her benefit payments in his or her own best interest without restriction. (A physical disability which prevents the veteran from attending to financial matters in person is not a proper basis for a finding of incompetency unless the veteran is, by reason of that disability, incapable of directing someone else in handling the individual's financial affairs.)
9. If smell or taste is affected, also complete the appropriate worksheet.

D. **Diagnostic and Clinical Tests:**

1. Skull X-rays to measure bony defect, if there was surgery; spine X-rays if there was spinal cord surgery.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

CRANIAL NERVES

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. If flare-ups exist, describe precipitating factors, aggravating factors, alleviating factors, alleviating medications, frequency, severity, duration and whether the flare-ups include pain, weakness, fatigue or functional loss.
2. Current treatment, response, side effects.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. Identify the nerve and the side.
2. Identify the disorder (i.e., paralysis, neuritis, neuralgia).
3. Describe in detail specific motor and sensory impairment, quantifying as much as possible.
4. If smell or taste is affected, please also complete the appropriate worksheet.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. State etiology.

Signature: Date:

Compensation and Pension Examination

NEUROLOGICAL DISORDERS, MISCELLANEOUS
(Migraine, Tic, Paramyoclonus Multiplex,
Sydenham's and Huntington's Chorea, and Athetosis)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Onset and course - If flare-ups exist, describe precipitating factors, aggravating factors, alleviating factors, alleviating medications, frequency, severity, duration, and whether the flare-ups include pain, weakness, fatigue or functional loss.
2. Current treatment, response, side effects.

C. **Physical Examination (Objective Findings):**

1. If Migraine: - Obtain the history of frequency and duration of attacks and description of level of activity the veteran can maintain during the attacks. For example, state if the attacks are prostrating in nature or if ordinary activity is possible.

2. If Tics and Paramyoclonus Complex: - Ascertain the muscle group(s) involved and obtain the best possible history of frequency and severity of attacks. State the effects on daily activities.

3. If Chorea, Choreiform Disorders, etc.: - Describe manifestations by impairment of strength, coordination, tremor, etc., with particular attention to the effects of the performance of ordinary activities of daily living.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

PERIPHERAL NERVES

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Onset and course - If flare-ups exist, describe precipitating factors, aggravating factors, alleviating factors, alleviating medications, frequency, severity, duration and whether the flare-ups include pain, weakness, fatigue or functional loss.
2. Current treatment, response, and side effects.
3. Paresthesias, dysesthesias, other sensory abnormalities.
4. Describe extent to which condition interferes with daily activity.
5. Specify nerves involved.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. If the disability is the result of brain disease or injury, spinal cord disease or injury, cervical disc disease, or trauma to the nerve roots themselves:
    a. Report sensory and motor impairment by reference to the distribution of the affected groups as paralysis, neuritis or neuralgia.
    b. Report each affected extremity separately.
2. If disability is NOT from the above:
    a. Identify the specific major nerve involved, localize the lesion and describe specific impairment of motor and sensory function, fine motor control, etc.
    b. Characterize as paralysis, neuritis or neuralgia, and indicate whether any muscle wasting or atrophy represents direct effect of nerve damage or merely disuse.
    c. Report each affected extremity separately.
3. For each joint that is affected:
    a. Using a goniometer, measure the <u>passive</u> and <u>active</u> range of motion, including movement against gravity and against strong resistance.
    b. If the joint is painful on motion, state at what point in the range of motion pain begins and ends.
    c. State to what extent, if any, the range of motion or function is <u>additionally limited</u> by pain, fatigue, weakness, or lack of endurance. If more than one of these is present, state, if possible, which has the major functional impact.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. State etiology.

Signature: Date:

Compensation and Pension Examination

EPILEPSY AND NARCOLEPSY

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Discuss precipitating factors, aggravating factors, alleviating factors.
2. Current treatment, response, side effects.
3. State the frequency and type of seizures or episodes of narcolepsy during the past 12 months, including any change in frequency pattern. If possible, record the actual number of seizures in each calendar month. If the veteran keeps a seizure diary, record dates of seizures.
4. Discuss the effect of epilepsy or narcolepsy on daily activities, including the effects of medications.

C. **Physical Examination (Objective Findings):**

1. Order a psychiatric examination if there are indications of a mental disorder associated with epilepsy.

D. **Diagnostic and Clinical Tests:**

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. If the diagnosis is NOT established or is questioned, schedule any necessary special studies, including admission for a period of examination and observation, as appropriate to provide a definitive diagnosis.

Signature: Date:

Compensation and Pension Examination

INITIAL EVALUATION FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. Identifying Information

_ age
_ ethnic background
_ era of military service
_ reason for referral (original exam to establish PTSD diagnosis and related psychosocial impairment; re-evaluation of status of existing service-connected PTSD condition)

B. Sources of Information

- records reviewed (C-file, DD-214, medical records, other documentation)
- review of social-industrial survey completed by social worker
- statements from collaterals
- administration of psychometric tests and questionnaires (identify here)

C. Review of Medical Records:

1. Past Medical History:

a. Previous hospitalizations and outpatient care.
b. Complete medical history is required, including history since discharge from military service.
c. Review of Claims Folder is required on initial exams to establish or rule out the diagnosis.

2. Present Medical History - over the past one year.

a. Frequency, severity and duration of medical and psychiatric symptoms.
b. Length of remissions, to include capacity for adjustment during periods of remissions.

D. Examination (Objective Findings):

Address each of the following and fully describe:

History (Subjective Complaints):

Comment on:

Premilitary History (refer to social-industrial survey if completed)

- describe family structure and environment where raised (identify constellation of family members and quality of relationships)
- quality of peer relationships and social adjustment (e.g., activities, achievements, athletic and/or extracurricular involvement, sexual involvements, etc.)
- education obtained and performance in school
- employment
- legal infractions
- delinquency or behavior conduct disturbances
- substance use patterns
- significant medical problems and treatments obtained

- family psychiatric history
- exposure to traumatic stressors (see CAPS trauma assessment checklist)
- summary assessment of psychosocial adjustment and progression through developmental milestones (performance in employment or schooling, routine responsibilities of self-care, family role functioning, physical health, social/interpersonal relationships, recreation/leisure pursuits).

Military History

- branch of service (enlisted or drafted)
- dates of service
- dates and location of war zone duty and number of months stationed in war zone
- Military Occupational Specialty (describe nature and duration of job(s) in war zone
- highest rank obtained during service (rank at discharge if different)
- type of discharge from military
- describe routine combat stressors veterans was exposed to (refer to Combat Scale)
- combat wounds sustained (describe)
- **clearly describe specific stressor event(s) veteran considered particularly traumatic**. Clearly describe the stressor. Particularly if the stressor is a type of personal assault, including sexual assault, provide information, with examples, if possible.
- indicate overall level of traumatic stress exposure (high, moderate, low) based on frequency and severity of incident exposure (refer to trauma assessment scale scores described in Appendix B).
- citations or medals received
- disciplinary infractions or other adjustment problems during military

NOTE: Service connection for post-traumatic stress disorder (PTSD) requires medical evidence establishing a diagnosis of the condition that conforms to the diagnostic criteria of DSM-IV, credible supporting evidence that the claimed in-service stressor actually occurred, and a link, established by medical evidence, between current symptomatology and the claimed in-service stressor. It is the responsibility of the examiner to indicate the traumatic stressor leading to PTSD, if he or she makes the diagnosis of PTSD. *Crucial in this description are specific details of the stressor, with names, dates, and places linked to the stressor, so that the rating specialist can confirm that the cited stressor occurred during active duty.*

A diagnosis of PTSD cannot be adequately documented or ruled out without obtaining a detailed military history and reviewing the claims folder. This means that initial review of the folder prior to examination, the history and examination itself, and the dictation for an examination initially establishing PTSD will often require more time than for examinations of other disorders. Ninety minutes to two hours on an initial exam is normal.

Post-Military Trauma History (refer to social-industrial survey if completed)

- describe post-military traumatic events (see CAPS trauma assessment checklist)
- describe psychosocial consequences of post-military trauma exposure(s) (treatment received, disruption to work, adverse health consequences)

Post-Military Psychosocial Adjustment (refer to social-industrial survey if completed)

- legal history (DWIs, arrests, time spent in jail)
- educational accomplishment
- employment history (describe periods of employment and reasons)
- marital and family relationships (including quality of relationships with children)
- degree and quality of social relationships
- activities and leisure pursuits
- problematic substance abuse (lifetime and current)

- significant medical disorders (resulting pain or disability; current medications)
- treatment history for significant medical conditions, including hospitalizations
- history of inpatient and/or outpatient psychiatric care (dates and conditions treated)
- history of assaultiveness
- history of suicide attempts
- summary statement of current psychosocial functional status (performance in employment or schooling, routine responsibilities of self care, family role functioning, physical health, social/interpersonal relationships, recreation/leisure pursuits)

E. Mental Status Examination

Conduct a brief mental status examination aimed at screening for DSM-IV mental disorders. Describe and fully explain the existence, frequency and extent of the following signs and symptoms, or any others present, and relate how they interfere with employment and social functioning:

- Impairment of thought process or communication.
- Delusions, hallucinations and their persistence.
- Eye Contact, interaction in session, and inappropriate behavior cited with examples.
- Suicidal or homicidal thoughts, ideations or plans or intent.
- Ability to maintain minimal personal hygiene and other basic activities of daily living.
- Orientation to person, place and time.
- Memory loss, or impairment (both short and long-term).
- Obsessive or ritualistic behavior which interferes with routine activities and describe any found.
- Rate and flow of speech and note any irrelevant, illogical, or obscure speech patterns and whether constant or intermittent.
- Panic attacks noting the severity, duration, frequency and effect on independent functioning and whether clinically observed or good evidence of prior clinical or equivalent observation is shown.
- Depression, depressed mood or anxiety.
- Impaired impulse control and its effect on motivation or mood.
- Sleep impairment and describe extent it interferes with daytime activities.
- Other disorders or symptoms and the extent they interfere with activities, particularly:

  _ mood disorders (especially major depression and dysthymia)
  _ substance use disorders (especially alcohol use disorders)
  _ anxiety disorders (especially panic disorder, obsessive-compulsive disorder, generalized anxiety disorder)
  _ somatoform disorders
  _ personality disorders (especially antisocial personality disorder and borderline personality disorder)

Specify onset and duration of symptoms as acute, chronic, or with delayed onset.

F. Assessment of PTSD

- state whether or not the veteran meets the DSM-IV stressor criterion
- identify behavioral, cognitive, social, affective, or somatic change veteran attributes to stress exposure
- describe specific PTSD symptoms present (symptoms of trauma re-experiencing, avoidance/numbing, heightened physiological arousal, and associated features [e.g., disillusionment and demoralization])
- specify onset, duration, typical frequency, and severity of symptoms

G. Psychometric Testing Results

- provide psychological testing if deemed necessary
- provide specific evaluation information required by the rating board or on a **BVA Remand**.

- comment on validity of psychological test results
- provide scores for PTSD psychometric assessments administered
- state whether PTSD psychometric measures are consistent or inconsistent with a diagnosis of PTSD, based on normative data and established "cutting scores" (cutting scores that are consistent with or supportive of a PTSD diagnosis are as follows: PCL $\geq$ 50; Mississippi Scale $\geq$ 107; MMPI PTSD subscale a score > 28; MMPI code type: 2-8 or 2-7-8)
- state degree of severity of PTSD symptoms based on psychometric data (mild, moderate, or severe)
- describe findings from psychological tests measuring problems other than PTSD (MMPI, etc.)

H. Diagnosis:

1. The Diagnosis must conform to DSM-IV and be supported by the findings on the examination report.
2. If there are multiple mental disorders, delineate to the extent possible the symptoms associated with each and a discussion of relationship.
3. Evaluation is based on the effects of the signs and symptoms on occupational and social functioning.

NOTE: VA is prohibited by statute from paying compensation for a disability that is a result of the veteran's own **ALCOHOL OR DRUG ABUSE**, whether based on direct service connection, secondary service connection, or aggravation by a service-connected condition. Therefore, when alcohol or drug abuse accompanies or is associated with another mental disorder, separate, to the extent possible, the effects of the alcohol or drug abuse from the effects of the other mental disorder(s). If it is not possible to separate the effects, explain why.

I. Diagnostic Status

Axis I disorders
Axis II disorders
Axis III disorders
Axis IV (psychosocial and environmental problems)
Axis V (GAF score - current)

J. Global Assessment of Functioning (GAF):

NOTE: The complete multi-axial format as specified by DSM-IV may be required by BVA REMAND or specifically requested by the rating specialist. If so, include the GAF score and note whether it refers to current functioning. A BVA REMAND may also request, in addition to an overall GAF score, that a separate GAF score be provided for each mental disorder present when there are multiple Axis I or Axis II diagnoses and not all are service-connected. If separate GAF scores can be given, an explanation and discussion of the rationale is needed. If it is not possible, an explanation as to why not is needed. (See the above note pertaining to alcohol or drug abuse, the effects of which cannot be used to assess the effects of a service-connected condition.)

DSM-IV is only for application from 11/7/96 on. Therefore, when applicable note whether the diagnosis of PTSD was supportable under DSM-III-R prior to that date. The prior criteria under DSM-III-R are provided as an attachment.

K. Competency: Competency, for benefits purposes, has a special meaning, and refers only to veterans' ability to manage benefit payments in their own best interests without restriction, and not to any other subject. State whether the veteran is capable of managing his/her or her benefit payments in the individual's own best interests (a physical disability which prevents the veteran from attending to financial matters in person is not a proper basis for a finding of incompetency unless the veteran is, by reason of that disability, incapable of directing someone else in handling the individual's financial affairs).

L. Other Opinion: Furnish any other specific opinion requested by the rating board or BVA remand (furnish the complete rationale and citation of medical texts or treatise supporting opinion, if medical literature review was undertaken). If the requested opinion is medically not ascertainable on exam or testing please state **why**. If the requested opinion can not be expressed without resorting to speculation or making improbable assumptions say so, and explain why. If the opinion asks " ... is it at least as likely as not ... ", fully explain the clinical findings and rationale for the opinion.

M. Integrated Summary and Conclusions

_ Describe changes in psychosocial functional status and quality of life following trauma exposure (performance in employment or schooling, routine responsibilities of self care, family role functioning, physical health, social/interpersonal relationships, recreation/leisure pursuits)

_ Describe linkage between PTSD symptoms and aforementioned changes in impairment in functional status and quality of life. *Particularly in cases where a veteran is unemployed, specific details about the effects of PTSD and its symptoms on employment are especially important.*

_ If possible, describe extent to which disorders other than PTSD (e.g., substance use disorders) are independently responsible for impairment in psychosocial adjustment and quality of life. If this is not possible, explain why (e.g., substance use had onset after PTSD and clearly is a means of coping with PTSD symptoms).

_ If possible, describe pre-trauma risk factors or characteristics than may have rendered the veteran vulnerable to developing PTSD subsequent to trauma exposure.

_ If possible, state prognosis for improvement of psychiatric condition and impairments in functional status.

_ Comment on whether veteran should be rated as competent for VA purposes in terms of being capable of managing his/her benefit payments in his/her own best interest.

Signature: **Date:**

Compensation and Pension Examination

REVIEW EXAMINATION FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

Name: **SSN:**

Date of Exam: **C-number:**

Place of Exam:

A: Review of Medical Records.

B. Medical History since last exam:

Comment on:

1. Hospitalizations and outpatient care from the time between last rating examination to the present, UNLESS the purpose of this examination is to ESTABLISH service connection, then the complete medical history since discharge from military service is required.
2. Frequency, severity and duration of psychiatric symptoms.
3. Length of remissions from psychiatric symptoms, to include capacity for adjustment during periods of remissions.
4. Treatments including statement on effectiveness and side effects experienced.
5. Subjective Complaints: Describe fully.

C. Psychosocial Adjustment since the last exam

- legal history (DWIs, arrests, time spent in jail)
- educational accomplishment
- extent of time lost from work over the past 12 month period and social impairment. If employed, identify current occupation and length of time at this job. *If unemployed, note in complaints whether veteran contends it is due to the effects of a mental disorder. Further indicate following* ***DIAGNOSIS*** *what factors, and objective findings support or rebut that contention.*
- marital and family relationships (including quality of relationships with spouse and children)
- degree and quality of social relationships
- activities and leisure pursuits
- problematic substance abuse
- significant medical disorders (resulting pain or disability; current medications)
- history of violence / assaultiveness
- history of suicide attempts
- summary statement of current psychosocial functional status (performance in employment or schooling, routine responsibilities of self care, family role functioning, physical health, social/interpersonal relationships, recreation/leisure pursuits)

D. Mental Status Examination

Conduct a brief mental status examination aimed at screening for DSM-IV mental disorders. Describe and fully explain the existence, frequency and extent of the following signs and symptoms, or any others present, and relate how they interfere with employment and social functioning:

- Impairment of thought process or communication.
- Delusions, hallucinations and their persistence.
- Eye contact, interaction in session, and inappropriate behavior cited with examples.

- Suicidal or homicidal thoughts, ideations or plans or intent.
- Ability to maintain minimal personal hygiene and other basic activities of daily living.
- Orientation to person, place and time.
- Memory loss, or impairment (both short and long-term).
- Obsessive or ritualistic behavior which interferes with routine activities and describe any found.
- Rate and flow of speech and note any irrelevant, illogical, or obscure speech patterns and whether constant or intermittent.
- Panic attacks noting the severity, duration, frequency and effect on independent functioning and whether clinically observed or good evidence of prior clinical or equivalent observation is shown.
- Depression, depressed mood or anxiety.
- Impaired impulse control and its effect on motivation or mood.
- Sleep impairment and describe extent it interferes with daytime activities.
- Other disorders or symptoms and the extent they interfere with activities, particularly:

  _ mood disorders (especially major depression and dysthymia)
  _ substance use disorders (especially alcohol use disorders)
  _ anxiety disorders (especially panic disorder, obsessive-compulsive disorder, generalized anxiety disorder)
  _ somatoform disorders
  _ personality disorders (especially antisocial personality disorder and borderline personality disorder)

E. Assessment of PTSD

- state whether or not the veteran currently meets the DSM-IV stressor criterion
- identify behavioral, cognitive, social, affective, or somatic symptoms veteran attributes to PTSD
- describe specific PTSD symptoms present (symptoms of trauma re-experiencing, avoidance/numbing, heightened physiological arousal, and associated features [e.g., disillusionment and demoralization])
- specify typical frequency and severity of symptoms

F. Psychometric Testing Results

- provide psychological testing if deemed necessary
- provide specific evaluation information required by the rating board or on a **BVARemand**.
- comment on validity of psychological test results
- provide scores for PTSD psychometric assessments administered
- state whether PTSD psychometric measures are consistent or inconsistent with a diagnosis of PTSD, based on normative data and established "cutting scores" (cutting scores that are consistent with or supportive of a PTSD diagnosis are as follows: PCL $\geq$ 50; Mississippi Scale $\geq$ 107; MMPI PTSD subscale a score > 28; MMPI code type: 2-8 or 2-7-8)
- state degree of severity of PTSD symptoms based on psychometric data (mild, moderate, or severe)
- describe findings from psychological tests measuring problems other than PTSD (MMPI, etc.)

G. Diagnosis:

1. The Diagnosis must conform to DSM-IV and be supported by the findings on the examination report.
2. If there are multiple mental disorders, delineate to the extent possible the symptoms associated with each and a discussion of relationship.
3. Evaluation is based on the effects of the signs and symptoms on occupational and social functioning.

NOTE: VA is prohibited by statute from paying compensation for a disability that is a result of the veteran's own ALCOHOL OR DRUG ABUSE, whether based on direct service connection, secondary service connection, or aggravation by a service-connected condition. Therefore, when alcohol or drug abuse accompanies or is associated with another mental disorder, separate, to the extent possible, the effects of the

alcohol or drug abuse from the effects of the other mental disorder(s). If it is not possible to separate the effects, explain why.

H. Diagnostic Status

Axis I disorders
Axis II disorders
Axis III disorders
Axis IV (psychosocial and environmental problems)
Axis V (GAF score: current)

I. Global Assessment of Functioning (GAF):

NOTE: The complete multi-axial format as specified by DSM-IV may be required by BVA REMAND or specifically requested by the rating specialist. If so, include the GAF score and note whether it refers to current functioning. A BVA REMAND may also request, in addition to an overall GAF score, that a separate GAF score be provided for each mental disorder present when there are multiple Axis I or Axis II diagnoses and not all are service-connected. If separate GAF scores can be given, an explanation and discussion of the rationale is needed. If it is not possible, an explanation as to why not is needed. (See the above note pertaining to alcohol or drug abuse, the effects of which cannot be used to assess the effects of a service-connected condition.)

J. Competency: Competency, for benefits purposes, has a special meaning, and refers only to veterans' ability to manage benefit payments in their own best interests without restriction, and not to any other subject. State whether the veteran is capable of managing his/her or her benefit payments in the individual's own best interests (a physical disability which prevents the veteran from attending to financial matters in person is not a proper basis for a finding of incompetency unless the veteran is, by reason of that disability, incapable of directing someone else in handling the individual's financial affairs).

K. **Other Opinion:** Furnish any other specific opinion requested by the rating board or BVA remand (i.e., furnish the complete rationale and citation of medical texts or treatise supporting opinion, if medical literature review was undertaken). If the requested opinion is medically not ascertainable on exam or testing please state **why**. If the requested opinion can not be expressed without resorting to speculation or making improbable assumptions say so, and explain why. If the opinion asks " ... is it at least as likely as not ... ", fully explain the clinical findings and rationale for the opinion.

L. Integrated Summary and Conclusions

1. Describe changes in psychosocial functional status and quality of life since the last exam (performance in employment or schooling, routine responsibilities of self care, family role functioning, physical health, social/interpersonal relationships, recreation/leisure pursuits).
2. Describe linkage between PTSD symptoms and aforementioned changes in impairment in functional status and quality of life. *Particularly in cases where a veteran is unemployed, specific details about the effects of PTSD and its symptoms on employment are especially important.*
3. If possible, describe extent to which disorders other than PTSD (e.g., substance use disorders) are independently responsible for impairment in psychosocial adjustment and quality of life. If this is not possible, explain why (e.g., substance use had onset after PTSD and clearly is a means of coping with PTSD symptoms).
4. If possible, state prognosis for improvement of psychiatric condition and impairments in functional status.
5. Comment on whether veteran should be rated as competent for VA purposes in terms of being capable of managing his/her benefit payments in his/her own best interest.

Signature: **Date:**

Compensation and Pension Examination

MENTAL DISORDERS (except PTSD and Eating Disorders)

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A: **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Past Medical History:
    a. Previous hospitalizations and outpatient care.
    b. Medical and occupational history from the time between last rating examination and the present, UNLESS the purpose of this examination is to ESTABLISH service connection, then the complete medical history since discharge from military service is required.

2. Present Medical, Occupational, and Social History - over the past one year.
    a. Frequency, severity and duration of psychiatric symptoms.
    b. Length of remissions, to include capacity for adjustment during periods of remissions.
    c. Extent of time lost from work over the past 12 month period and social impairment. If employed, identify current occupation and length of time at this job. If unemployed, note in complaints whether veteran contends it is due to the effects of a mental disorder. Further indicate following **DIAGNOSIS** what factors, and objective findings support or rebut that contention.
    d. Treatments including statement on effectiveness and side effects experienced.

3. Subjective Complaints:
    a. Describe fully.

C. **Examination (Objective Findings):**

Address each of the following and fully describe:

1. Mental status exam to confirm or establish diagnosis in accordance with DSM-IV.
2. Additionally, to allow evaluation by the rating specialist, describe and fully explain the existence, frequency, and extent of the following signs and symptoms, or any others present, and relate how they interfere with employment and social functioning:
    a. Impairment of thought process or communication.
    b. Delusions, hallucinations and their persistence.
    c. Inappropriate behavior cited with examples.
    d. Suicidal or homicidal thoughts, ideations or plans or intent.
    e. Ability to maintain minimal personal hygiene and other basic activities of daily living.
    f. Orientation to person, place and time.
    g. Memory loss or impairment (both short and/or long term).
    h. Obsessive or ritualistic behavior which interferes with routine activities (describe with examples).

i. Rate and flow of speech and note irrelevant, illogical, or obscure speech patterns and whether constant or intermittent.
j. Panic attacks noting the severity, duration, frequency and effect on independent functioning and whether clinically observed or good evidence of prior clinical or equivalent observation.
k. Depression, depressed mood or anxiety.
l. Impaired impulse control and its effect on motivation or mood.
m. Sleep impairment and describe extent it interferes with daytime activities.
n. Other symptoms and the extent to which they interfere with activities.

D. **Diagnostic Tests:**

1. Provide psychological testing if deemed necessary.
2. If testing is requested, the results must be reported and considered in arriving at the diagnosis.
3. Provide any specific evaluation information required by the rating board or on **BVA Remand** (in claims folder).

    a. **Competency:** State whether the veteran is capable of managing his/her benefit payments in the individual's own best interests (a physical disability which prevents the veteran from attending to financial matters in person is not a proper basis for a finding of incompetency unless the veteran is, by reason of that disability, incapable of directing someone else in handling the individual's financial affairs).

    b. **Other Opinion:** Furnish any other specific opinion requested by the rating board or BVA Remand furnishing the complete rationale and citation of medical texts or treatise supporting opinion, if medical literature review was undertaken. If the requested opinion is medically not ascertainable on exam or testing, please indicate **why.** If the requested opinion can not be expressed without resorting to speculation or making improbable assumptions say so, and explain why. If the opinion asks "...is it at least as likely as not...?", fully explain the clinical findings and rationale for the opinion.

4. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Provide:

1. The Diagnosis must conform to DSM-IV and be supported by the findings on the examination report.
2. If the diagnosis is changed, explain fully whether the new diagnosis represents a progression of the prior diagnosis or development of a new and separate condition.
3. If there are multiple mental disorders, delineate to the extent possible the symptoms associated with each and a discussion of relationship.
4. Evaluation is based on the effects of the signs and symptoms on occupational and social functioning.

.

NOTE: VA is prohibited by statute from paying compensation for a disability that is a result of the veteran's own **ALCOHOL OR DRUG ABUSE**, whether based on direct service connection, secondary service connection, or aggravation by a service-connected condition. Therefore, when alcohol or drug abuse accompanies or is associated with another mental disorder, separate, to the extent possible, the effects of the alcohol or drug abuse from the effects of the other mental disorder(s). If it is not possible to separate the effects, explain why.

F. **Global Assessment of Functioning (GAF):**

NOTE: The complete multi-axial format as specified by DSM-IV may be required by BVA REMAND or specifically requested by the rating specialist. If so, include the GAF score and note whether it refers to current functioning. A BVA REMAND may also request, in addition to an overall GAF score, that a separate GAF score be provided for each mental disorder present when there are multiple Axis I or Axis II diagnoses and not all are service-connected. If separate GAF scores can be given, an explanation and discussion of the rationale is needed. If it is not possible, an explanation as to why not is needed. (See the above note pertaining to alcohol or drug abuse, the effects of which cannot be used to assess the effects of a service-connected condition.)

Signature: Date:

Compensation and Pension Examination

EATING DISORDERS (Mental Disorders)

Name: SSN:

Date of Exam: C-number:

Place of Exam

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

Comment on:

1. Past Medical History:
    a. Previous hospitalizations and outpatient care for parenteral nutrition or tube feeding.
    b. Medical and occupational history from the time between the last such rating examination and the present needs to be accounted for, UNLESS the purpose of this examination is to ESTABLISH service connection, then a complete medical history since discharge from military service is required.
    c. Periods of incapacitation (during which bedrest and treatment by a physician are required due to the eating disorder). Describe the frequency and duration.
    d. Current treatment, response, side effects.

2. Present Medical, Occupational and Social History - over the past one year.
    a. History of onset of eating disorder.
    b. Its course, treatment, and current status to include symptoms.
    c. Extent of time lost from work over the past 12 month period and social impairment. If employed, identify current occupation and length of time at this job.

3. Subjective Complaints:
    a. Describe fully.

C. **Examination (Objective Findings):**

Address each of the following and fully describe:

1. Mental status exam to confirm or establish diagnosis in accordance with DSM-IV.
2. Additionally, please provide this specific information: a. Current weight.
    b. Expected minimum weight based on age, height, and body build.
    c. Obtain weight history.

3. Additionally, to allow evaluation by the rating specialist, describe and fully explain the existence, frequency, and extent of the following signs and symptoms and relate how they interfere with employment:
    a. Binge eating.
    b. Self-induced vomiting or other measure to prevent weight gain when weight is already below expected minimum normal weight.

D. **Diagnostic Tests** (including psychological testing if deemed necessary):

1. Provide specific evaluation information required by the rating board or on a BVA Remand. Diagnostic Tests (See the examination request remarks for specifics.):

a. **Competency:** State whether the veteran is capable of managing his or her benefit payments in the individual's own best interests (a physical disability which prevents the veteran from attending to financial matters in person is not a proper basis for a finding of incompetency unless the veteran is, by reason of that disability, incapable of directing someone else in handling the individual's financial affairs).

b. **Other Opinion:** Furnish any other specific opinion requested by the rating board or BVA Remand furnishing the complete rationale and citation of medical texts or treatise supporting opinion, if medical literature review was undertaken. If the requested opinion is medically not ascertainable on exam or testing please state WHY. If the requested opinion can not be expressed without resorting to speculation or making improbable assumptions say so, and explain why. If the opinion asks "...is it at least as likely as not...", fully explain the clinical findings and rationale for the opinion.

2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

Signature: Date:

Compensation and Pension Examination

DENTAL AND ORAL

Name: SSN:

Date of Exam: C-number:

Place of Exam:

Narrative: Regional Office action is required for all dental treatment based on combat wounds, service trauma, prisoner of war or extracted teeth under 38 CFR 17.123.

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe:

1. Describe extent of functional impairment due to loss of motion and masticatory function loss.
2. Describe the extent and number of missing teeth and whether the masticatory surface can be replaced by a prosthesis.
3. If limitation of inter-incisal range of motion, provide actual range in mm (i.e., 0-Xmm) and also provide lateral excursion (i.e., 0-Xmm).
4. Describe the extent of any bone loss of mandible, maxilla, or hard palate. For hard palate and maxilla bone loss, state whether replaceable by prosthesis.

D. **Diagnostic and Clinical Tests:**

Provide:

1. X-ray to determine extent of bone tissue loss.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. Give etiology where there is loss of teeth due to loss of substance of body of maxilla or mandible.

Signature: Date:

Compensation and Pension Examination

COLD INJURY PROTOCOL EXAMINATION

Name: SSN:

Date of Exam: C-number:

Place of Exam:

Narration: Veterans during World War II, the Korean War, and in smaller numbers during other campaigns, have suffered cold injuries, including frostbite (freezing cold injury or FCI) and immersion foot (nonfreezing cold injury or NCI). Documentation of such injuries may be lacking because of battlefield conditions. A number of long-term and delayed sequelae to cold injuries are recognized, including peripheral neuropathy, skin cancer in frostbite scars, and arthritis in involved limbs.

Review Examination: Any veteran examined for residuals of cold injury should undergo a cold injury protocol examination **if** it has not already been carried out. If the veteran has already had a cold injury protocol examination, only an interval history is required, and the extent of the examination, laboratory tests performed, etc., will be determined by the examiner based on the history, and as requested.

A. **Review of Medical Records:**

B. **Medical History (Subjective Complaints):**

History of Cold Injury: If the cold injury protocol form has been filled out by the veteran, most details about the circumstances of the acute cold injury and its subsequent course will be recorded. Review for any needed expansion or clarification by the veteran. If the protocol history form has not been completed, obtain the following history and comment on each:

1. Description of the circumstances of the cold injury.
2. Parts of the body affected.
3. Signs and symptoms - at time of acute injury.
4. The type of treatment and where it was administered.
5. Any treatment since service - where and what type.
6. Current symptoms - specifically inquire about:
    a. Amputations or other tissue loss.
    b. Cold sensitization.
    c. Raynaud's phenomenon.
    d. Hyperhidrosis.
    e. Paresthesias, numbness.
    f. Chronic pain resembling causalgia or reflex sympathetic dystrophy.
    g. Recurrent fungal infections.
    h. Breakdown or ulceration of frostbite scars.
    i. Disturbances of nail growth.
    j. Skin cancer in chronic ulcers or scars.
    k. Arthritis or joint stiffness, including limitation of motion of affected areas.
    l. Edema.
    m. Changes in skin color.
    n. Skin thickening or thinning.
    o. Any sleep disturbance due to associated symptoms.
    p. Cold feeling (relationship to season or not).
    q. Numbness, tingling, burning.
    r. Excess sweating.
    s. Pain - location, intensity, constancy, precipitating factors (cold, walking,

standing, night pain); type (sharp burning, etc.).

7. Current treatment, including nonmedical measures taken - moving to warmer climate, wearing multiple pairs of socks, etc.

Other Medical History:

1. Major illnesses, surgery, current medical conditions and their treatment, including diabetes mellitus or hypertension.
2. Smoking history, other risk factors for vascular disease, history of skin cancer.

C. **Physical Examination (Objective Findings):**

Address each of the following and fully describe current findings:

1. **General:** Carriage, gait, posture.
2. **Skin:**
    a. Color.
    b. Edema.
    c. Temperature.
    d. Atrophy.
    e. Dry or moist.
    f. Texture.
    g. Ulceration.
    h. Hair growth.
    i. Evidence of fungus or other infection.
3. **Scars:**
    a. Location.
    b. Length.
    c. Width.
    d. Color.
    e. Tenderness.
    f. Raised or depressed.
    g. If of head or neck, any disfigurement.
4. **Nails:**
    a. All or part missing
    b. Evidence of fungus infection
    c. Deformed or atrophic
5. **Neurological:**
    a. Reflexes.
    b. Sensory - subjective complaints of pain, numbness, etc., Objective sensory changes - pinprick, touch.
    c. Motor - weakness, atrophy.
6. **Orthopedic:**
    a. Pain or stiffness of any joints affected by cold injury.
    b. Deformity or swelling of any joints.
    c. Measure range of motion of all affected joints.
    d. Strength of ligaments in affected areas.
    e. Pes planus.
    f. Callus.
    g. Pain on manipulation of joints.
    h. Loss of tissue of digits or other affected parts.
7. **Vascular:**
    a. Status of peripheral pulses.
    b. Doppler study to confirm vascular compromise, if indicated.
    c. Evidence of vascular insufficiency - edema, hair loss, shiny atrophic skin, etc.
    d. Blood pressure in arms and legs (is ratio normal?).

e. Evidence of Raynaud's phenomenon.

D. **Diagnostic and Clinical Tests:**

Provide:

1. X-rays of affected areas of extremities if never done or if not done in past five years.
2. Doppler study of blood vessels, if indicated.
3. Nerve conduction studies, if indicated.
4. Biopsy of any area suspicious for malignancy.
5. Scrapings to confirm fungus infection.
6. Include results of all diagnostic and clinical tests conducted in the examination report.

E. **Diagnosis:**

1. List each diagnosis and state whether related to cold injury (if that can be determined).
2. Specialty exams that might be needed:
    a. Neurology.
    b. Podiatry.
    c. Dermatology.
    d. Rheumatology.
    e. Others as needed.

Signature: Date:

HELPFUL HINTS FROM THE SEVEN STEPS TEAM:

There may be prescriptive language that appears to make a contract detail-oriented and not performance-based; however, agencies may have minimum requirements that must be met, such as the specific worksheets that must be documented for the VA Medical Disability Exams. We also see this when agencies are trying to leverage what has already been purchased that could be a component of the proposed solution. For example, if an agency knows it must use Microsoft software because all the licenses have already been purchased, then that would be something the agency would have to disclose when outlining the requirements. As long as the contract file documents why minimum requirements are contained in the contract and they are based on something that has a reasonable rationale or is mandatory, the contract can still be considered performance based.