OMB Approved No. 2900-0805
Respondent Burden: 30 minutes
Expiration Date: 04-30-2017

Department of Veterans Affairs

WRIST CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
15	14

NOTE TO PHYSICIAN - The veteran or service member is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

MEDICAL RECORD REVIEW

WAS THE VETERAN'S VA CLAIMS FILE REVIEWED?

2 YES 1 NO

IF YES, LIST ANY RECORDS THAT WERE REVIEWED BUT WERE NOT INCLUDED IN THE VETERAN'S VA CLAIMS FILE:

16

IF NO, CHECK ALL RECORDS REVIEWED:

- 3 Military service treatment records
- 4 Military service personnel records
- 5 Military enlistment examination
- 6 Military separation examination
- 7 Military post-deployment questionnaire
- 8 Department of Defense Form 214 Separation Documents
- 9 Veterans Health Administration medical records *(VA treatment records)*
- 10 Civilian medical records
- 11 Interviews with collateral witnesses *(family and others who have known the veteran before and after military service)*
- 13 Other: 18
- 12 No records were reviewed

SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS DBQ:

17

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) *(Check all that apply)*:

63 The Veteran does not have a current diagnosis associated with any claimed condition listed above. *(Explain your findings and reasons in comments section.)*

		Side affected: Right / Left / Both	ICD Code:	Date of diagnosis:
64	Wrist Sprain, Chronic	75 / 74 / 73	62	61
65	Tendinitis, wrist	21 / 57 / 58	59	60
66	Ganglion cyst	56 / 55 / 54	53	52
67	Carpal metacarpal *(CMC)* arthritis	22 / 48 / 49	50	51
68	Osteoarthritis arthritis, wrist	47 / 46 / 45	44	43
69	deQuervain's syndrome	23 / 39 / 40	41	42
70	Triangular fibrocartilaginous complex *(TFCC)* injury	38 / 37 / 36	35	34
71	Carpal instability *(intercalated segment/midcarpal/ scapholunate dissociation)*	24 / 30 / 31	32	33
72	Avascular necrosis of carpal bones	29 / 28 / 27	26	25
81	Wrist arthroplasty *(total/ulnar head replacement)*	80 / 79 / 78	77	76
87	Ankylosis of wrist	86 / 85 / 84	83	82

103 Other *(specify)*

Other diagnosis #1: 106

Side affected: 88 Right 99 Left 100 Both ICD Code: 101 Date of diagnosis: 102

Other diagnosis #2: 105

Side affected: 98 Right 97 Left 96 Both ICD Code: 95 Date of diagnosis: 94

Other diagnosis #3: 104

Side affected: 89 Right 90 Left 91 Both ICD Code: 92 Date of diagnosis: 93

SECTION I - DIAGNOSIS *(Continued)*

1C. COMMENTS *(if any):*

107

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION *(internal VA only)*?

120 YES 119 NO 118 N/A

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S WRIST CONDITION *(brief summary):*

108

2B. DOMINANT HAND:

111 RIGHT 112 LEFT 113 AMBIDEXTROUS

2C. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE WRIST?

117 YES 116 NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF THE IMPACT OF FLARE-UPS IN HIS OR HER OWN WORDS:

109

2D. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE JOINT OR EXTREMITY BEING EVALUATED ON THIS DBQ *(regardless of repetitive use)*?

114 YES 115 NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT IN HIS OR HER OWN WORDS:

110

SECTION III - INITIAL RANGE OF MOTION *(ROM)* MEASUREMENTS

Measure ROM with a goniometer. During the examination be cognizant of painful motion, which could be evidenced by visible behavior such as facial expression, wincing, etc..., on pressure or manipulation. Document painful movement in Section 5.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in question 4A.

3A. INITIAL ROM MEASUREMENTS

Wrist	Joint Movement	ROM Measurement	If ROM testing is not indicated for the veteran's condition or not able to be performed, please explain why, and then proceed to Section 5:
RIGHT WRIST All Normal	Palmar Flexion (normal endpoint = 80 degrees)	135 130 Not indicated 134 Not able to perform	136
	Dorsiflexion (normal endpoint = 70 degrees)	131 132 Not indicated 133 Not able to perform	137
	Ulnar Deviation (normal endpoint = 45 degrees)	123 128 Not indicated 124 Not able to perform	121
	Radial Deviation (normal endpoint = 20 degrees)	127 125 Not indicated 126 Not able to perform	122

SECTION III - INITIAL RANGE OF MOTION *(ROM)* MEASUREMENTS *(Continued)*

3A. INITIAL ROM MEASUREMENTS *(Continued)*

Wrist	Joint Movement	ROM Measurement	If ROM testing is not indicated for the veteran's condition or not able to be performed, please explain why, and then proceed to Section 5:
LEFT WRIST All Normal	Palmar Flexion (normal endpoint = 80 degrees)	156 151 Not indicated 155 Not able to perform	157
	Dorsiflexion (normal endpoint = 70 degrees)	152 153 Not indicated 154 Not able to perform	158
	Ulnar Deviation (normal endpoint = 45 degrees)	144 149 Not indicated 145 Not able to perform	142
	Radial Deviation (normal endpoint = 20 degrees)	148 146 Not indicated 147 Not able to perform	143

3B. DO ANY ABNORMAL ROMs NOTED ABOVE CONTRIBUTE TO FUNCTIONAL LOSS?

141 YES *(you will be asked to further describe these limitations in Section 6 below)*

140 NO, EXPLAIN WHY THE ABNORMAL ROMs DO NOT CONTRIBUTE:

139

3C. IF ROM DOES NOT CONFORM TO THE NORMAL RANGE OF MOTION IDENTIFIED ABOVE BUT IS NORMAL FOR THIS VETERAN *(for reasons other than a wrist condition, such as age, body habitus, neurologic disease),* EXPLAIN:

138

SECTION IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

4A. POST-TEST ROM MEASUREMENTS

Wrist	Is the veteran able to perform repetitive-use testing?	Is there additional limitation in ROM after repetitive-use testing?	Joint Movement	Post-test ROM Measurement
RIGHT WRIST	161 Yes 162 No If yes, perform repetitive-use testing If no, provide reason below, then proceed to Section 5 165	164 Yes 163 No, there is no change in ROM after repetitive testing If yes, report ROM after a minimum of 3 repetitions. If no, documentation of ROM after repetitive-use testing is not required.	Palmar Flexion	159
			Dorsiflexion	160
			Ulnar Deviation	166
			Radial Deviation	167
LEFT WRIST	178 Yes 177 No If yes, perform repetitive-use testing If no, provide reason below, then proceed to Section 5 174	175 Yes 176 No, there is no change in ROM after repetitive testing If yes, report ROM after a minimum of 3 repetitions. If no, documentation of ROM after repetitive-use testing is not required.	Palmar Flexion	179
			Dorsiflexion	173
			Ulnar Deviation	171
			Radial Deviation	172

4B. DO ANY POST-TEST ADDITIONAL LIMITATIONS OF ROMs NOTED ABOVE CONTRIBUTE TO FUNCTIONAL LOSS?

170 YES *(you will be asked to further describe these limitations in Section 6 below)*

169 NO, EXPLAIN WHY THE POST-TEST ADDITIONAL LIMITATIONS OF ROMs DO NOT CONTRIBUTE:

168

SECTION V - PAIN

5A. ROM MOVEMENTS PAINFUL ON ACTIVE, PASSIVE AND/OR REPETITIVE USE TESTING

	Are any ROM movements painful on active, passive and/or repetitive use testing? *(If yes, identify whether active, passive, and/or repetitive use in question 5D)*	If yes *(there are painful movements)*, does the pain contribute to functional loss or additional limitation of ROM?	If no *(the pain does not contribute to functional loss or additional limitation of ROM)*, explain why the pain does not contribute:
RIGHT WRIST	185 Yes 186 No	187 Yes *(you will be asked to further describe these limitations in Section 6 below)* 188 No	189
LEFT WRIST	197 Yes 194 No	195 Yes *(you will be asked to further describe these limitations in Section 6 below)* 196 No	198

5B. PAIN WHEN USED IN WEIGHT-BEARING OR IN NON WEIGHT-BEARING

	Is there pain when the joint is used in weight-bearing or non weight? *(If yes, identify whether weight-bearing or non weight-bearing in question 5D)*	If yes *(there is pain when used in weight-bearing or non weight-bearing)*, does the pain contribute to functional loss or additional limitation of ROM?	If no *(the pain does not contribute to functional loss or additional limitation of ROM)*, explain why the pain does not contribute:
RIGHT WRIST	203 Yes 202 No	201 Yes *(you will be asked to further describe these limitations in Section 6 below)* 200 No	199
LEFT WRIST	181 Yes 184 No	183 Yes *(you will be asked to further describe these limitations in Section 6 below)* 182 No	180

5C. LOCALIZED TENDERNESS OR PAIN ON PALPATION

	Does the Veteran have localized tenderness or pain to palpation of joints or soft tissue?	If yes, describe including location, severity and relationship to condition(s) listed in the Diagnosis section:
RIGHT WRIST	204 Yes 205 No	206
LEFT WRIST	191 Yes 190 No	192

5D. COMMENTS, IF ANY:

193

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION OF ROM

NOTE: The VA defines functional loss as the inability, due to damage or infection in parts of the system, to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance. As regards the joints, factors of disability reside in reductions of their normal excursion of movements in different planes.
Using information from the history and physical exam, select the factors below that contribute to functional loss or impairment (regardless of repetitive use) or to additional limitation of ROM after repetitive use for the joint or extremity being evaluated on this DBQ:

6A. CONTRIBUTING FACTORS OF DISABILITY *(check all that apply and indicate side affected)*:

255	No functional loss for left upper extremity attributable to claimed condition			
209	No functional loss for right upper extremity attributable to claimed condition			
210	Less movement than normal *(due to ankylosis, limitation or blocking, adhesions, tendon-tie-ups, contracted scars, etc.)*	252 Right	211 Left	253 Both
254	More movement than normal *(from flail joints, resections, nonunion of fractures, relaxation of ligaments, etc.)*	250 Right	251 Left	249 Both
208	Weakened movement *(due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.)*	247 Right	212 Left	248 Both
207	Excess fatigability	245 Right	246 Left	244 Both
261	Incoordination, impaired ability to execute skilled movements smoothly	242 Right	213 Left	243 Both
260	Pain on movement	240 Right	241 Left	239 Both
259	Swelling	237 Right	214 Left	238 Both
258	Deformity	235 Right	236 Left	234 Both
257	Atrophy of disuse	232 Right	215 Left	233 Both
216	Instability of station	230 Right	231 Left	229 Both
228	Disturbance of locomotion	226 Right	217 Left	227 Both
218	Interference with sitting	224 Right	225 Left	223 Both
222	Interference with standing	220 Right	219 Left	221 Both
256	Other, describe:			

262

NOTE: If any of the above factors is/are associated with limitation of motion, the examiner must give an opinion on whether pain, weakness, fatigability, or incoordination could significantly limit functional ability during flare-ups or when the joint is ***used repeatedly over a period of time*** and that opinion, if feasible, should be expressed in terms of the degree of additional ROM loss due to pain on use or during flare-ups. The following section will assist you in providing this required opinion.

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION OF ROM *(Continued)*

6B. ARE ANY OF THE ABOVE FACTORS ASSOCIATED WITH LIMITATION OF MOTION?

264 YES *(If yes, complete questions 6C and 6D)*

263 NO *(If no, proceed to question 6D)*

6C. CONTRIBUTING FACTORS OF DISABILITY ASSOCIATED WITH LIMITATION OF MOTION

Wrist	Can pain, weakness, fatigability, or incoordination significantly limit functional ability during flare-ups or when the joint is ***used repeatedly over a period of time?***	If yes, please estimate ROM due to pain and/or functional loss during flare-ups or when the joint is used repeatedly over a period of time:		If there is a functional loss due to pain, during flare-ups and/or when the joint is used repeatedly over a period of time but the limitation of ROM cannot be estimated, please describe the functional loss:
RIGHT WRIST	273 Yes 274 No	Palmar Flexion	272 ___ 271 Est. ROM is not feasible	275
		Dorsiflexion	265 ___ 270 Est. ROM is not feasible	
		Ulnar Deviation	266 ___ 269 Est. ROM is not feasible	
		Radial Deviation	268 ___ 267 Est. ROM is not feasible	
LEFT WRIST	285 Yes 284 No	Palmar Flexion	283 ___ 282 Est. ROM is not feasible	286
		Dorsiflexion	276 ___ 277 Est. ROM is not feasible	
		Ulnar Deviation	280 ___ 281 Est. ROM is not feasible	
		Radial Deviation	279 ___ 278 Est. ROM is not feasible	

6D. CONTRIBUTING FACTORS OF DISABILITY NOT ASSOCIATED WITH LIMITATION OF MOTION

IS THERE ANY FUNCTIONAL LOSS *(not associated with limitation of motion)* DURING FLARE-UPS OR WHEN THE JOINT IS USED REPEATEDLY OVER A PERIOD OF TIME OR OTHERWISE?

RIGHT WRIST: 288 Yes 289 No If yes, describe:

287

LEFT WRIST: 291 Yes 290 No If yes, describe:

292

SECTION VII - MUSCLE STRENGTH TESTING

7A. MUSCLE STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Wrist	Flexion /Extension	Rate Strength	Is there a reduction in muscle strength?	If yes, is the reduction entirely due to the claimed condition in the Diagnosis section?	If no (the reduction is not entirely due to the claimed condition), provide rationale:
RIGHT WRIST	Flexion	294 /5	297 Yes 298 No	300 Yes 299 No	295
All Normal	Extension	293 /5			
LEFT WRIST	Flexion	308 /5	307 Yes 306 No	304 Yes 305 No	302
All Normal	Extension	301 /5			

7B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

309 YES 310 NO

IF YES, IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

311 YES 312 NO IF NO, PROVIDE RATIONALE:

313

IF YES, CONTINUE ON PAGE 6, ITEM 7B *(Continued)*.

SECTION VII - MUSCLE STRENGTH TESTING *(Continued)*

7B. DOES THE VETERAN HAVE MUSCLE ATROPHY? *(Continued)*
FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSES LISTED IN SECTION 1, INDICATE SIDE AND SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK.

LOCATION OF MUSCLE ATROPHY:

317 RIGHT UPPER EXTREMITY *(specify location of measurement such as "10cm above or below elbow")*:

316

CIRCUMFERENCE OF MORE NORMAL SIDE: 315 cm CIRCUMFERENCE OF ATROPHIED SIDE: 314 cm

335 LEFT UPPER EXTREMITY *(specify location of measurement such as "10cm above or below elbow")*:

333

CIRCUMFERENCE OF MORE NORMAL SIDE: 318 cm CIRCUMFERENCE OF ATROPHIED SIDE: 334 cm

7C. COMMENTS, IF ANY:

336

SECTION VIII - ANKYLOSIS

NOTE: Ankylosis is the immobilization and consolidation of a joint due to disease, injury or surgical procedure.

COMPLETE THIS SECTION IF THE VETERAN HAS ANKYLOSIS OF THE WRIST.

8A. INDICATE SEVERITY OF ANKYLOSIS AND SIDE AFFECTED *(check all that apply)*:

RIGHT SIDE:

340 Unfavorable, with ulnar deviation
If checked, provide degrees of ulnar deviation: 319

339 Unfavorable, with radial deviation
If checked, provide degrees of radial deviation: 320

338 Unfavorable, in any degree of palmar flexion
If checked, provide degrees of palmar flexion: 321

325 Any other position except favorable
If checked, describe: 322

326 Favorable in 20º to 30º dorsiflexion

327 No ankylosis

LEFT SIDE:

341 Unfavorable, with ulnar deviation
If checked, provide degrees of ulnar deviation: 332

342 Unfavorable, with radial deviation
If checked, provide degrees of radial deviation: 331

343 Unfavorable, in any degree of palmar flexion
If checked, provide degrees of palmar flexion: 324

330 Any other position except favorable
If checked, describe: 323

328 Favorable in 20º to 30º dorsiflexion

329 No ankylosis

8B. COMMENTS, IF ANY:

337

SECTION IX - SURGICAL PROCEDURES

9. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED *(check all that apply)*:

RIGHT SIDE:

362 TOTAL WRIST JOINT REPLACEMENT
DATE OF SURGERY: 360
RESIDUALS:
361 None
364 Intermediate degrees of residual weakness, pain or limitation of motion
367 Chronic residuals consisting of severe painful motion or weakness
363 Other, describe:

358

366 ARTHROSCOPIC OR OTHER WRIST SURGERY
TYPE OF SURGERY: 356
DATE OF SURGERY: 359

365 RESIDUALS OF ARTHROSCOPIC OR OTHER WRIST SURGERY
DESCRIBE RESIDUALS:

357

LEFT SIDE:

349 TOTAL WRIST JOINT REPLACEMENT
DATE OF SURGERY: 351
RESIDUALS:
350 None
346 Intermediate degrees of residual weakness, pain or limitation of motion
347 Chronic residuals consisting of severe painful motion or weakness
348 Other, describe:

353

344 ARTHROSCOPIC OR OTHER WRIST SURGERY
TYPE OF SURGERY: 355
DATE OF SURGERY: 352

345 RESIDUALS OF ARTHROSCOPIC OR OTHER WRIST SURGERY
DESCRIBE RESIDUALS:

354

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

10A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS, OR ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

377 YES 376 NO IF YES, COMPLETE QUESTIONS 10B-10D.

10B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

370 YES 371 NO IF YES, DESCRIBE *(brief summary)*:

369

10C. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

372 YES 373 NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM *(6 square inches);* OR ARE LOCATED ON THE HEAD, FACE OR NECK?

374 YES 375 NO IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

Location: 378 Measurements: length 379 cm X width 380 cm.

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

10D. COMMENTS, IF ANY:

368

SECTION XI - ASSISTIVE DEVICES

11A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES?

382 YES 383 NO IF YES, IDENTIFY ASSISTIVE DEVICES USED *(check all that apply and indicate frequency):*

384 Brace Frequency of use: 386 Occasional 390 Regular 391 Constant

385 Other: 392 Frequency of use: 389 Occasional 388 Regular 387 Constant

11B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

381

SECTION XII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

12A. DUE TO THE VETERAN'S WRIST CONDITIONS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAIN OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)*

397 YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROTHESIS WOULD EQUALLY SERVE THE VETERAN.

396 NO

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES: 394 RIGHT UPPER 395 LEFT UPPER

FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES *(brief summary)*:

393

NOTE: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prothesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

SECTION XIII - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, even if in the past, no further imaging studies are required by VA, even if arthritis has worsened.

13A. HAVE IMAGING STUDIES OF THE WRIST BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

403 YES 402 NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

400 YES 401 NO IF YES, INDICATE WRIST: 404 RIGHT 398 LEFT 399 BOTH

SECTION XIII - DIAGNOSTIC TESTING *(Continued)*

13B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS OR RESULTS?

410 YES 411 NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

412

13C. IS THERE OBJECTIVE EVIDENCE OF CREPITUS?

407 YES 406 NO IF YES, INDICATE WRIST: 405 RIGHT 409 LEFT 408 BOTH

13D. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

413

SECTION XIV - FUNCTIONAL IMPACT

NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

14. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK *(such as standing, walking, lifting, sitting, etc.)*?

416 YES 415 NO IF YES, DESCRIBE THE FUNCTIONAL IMPACT OF EACH CONDITION, PROVIDING ONE OR MORE EXAMPLES:

414

SECTION XV - REMARKS

15. REMARKS, IF ANY:

424

SECTION XVI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

16A. PHYSICIAN'S SIGNATURE	16B. PHYSICIAN'S PRINTED NAME	16C. DATE SIGNED
423	420	419

16D. PHYSICIAN'S PHONE NUMBER	16E. PHYSICIAN'S MEDICAL LICENSE NUMBER	16F. PHYSICIAN'S ADDRESS
422	421	418

NOTE: VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to 417 _____

(VA Regional Office FAX No.)

NOTE: A list of VA Regional Office FAX Numbers can be found at **www.vba.va.gov/disabilityexams** or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.