OMB Approved No. 2900-0806
Respondent Burden: 30 minutes
Expiration Date: 04-30-2017

Department of Veterans Affairs

ANKLE 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
95	94

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?

69 YES 68 NO

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

96

IF NO, CHECK ALL RECORDS REVIEWED:

70 Military service treatment records
71 Military service personnel records
72 Military enlistment examination
73 Military separation examination
74 Military post-deployment questionnaire
75 Department of Defense Form 214 Separation Documents
76 Veterans Health Administration medical records *(VA treatment records)*
77 Civilian medical records
78 Interviews with collateral witnesses *(family and others who have known the veteran before and after military service)*
80 Other: 98
79 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:

97

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)*:

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

82	Lateral collateral ligament sprain *(chronic/recurrent)*	Side affected:	101	Right	100	Left	99	Both	ICD Code: 67	Date of diagnosis: 66
83	Deltoid ligament sprain *(chronic/recurrent)*	Side affected:	1	Right	62	Left	63	Both	ICD Code: 64	Date of diagnosis: 65
84	Osteochondritis dissecans to include osteochondral fracture	Side affected:	61	Right	60	Left	59	Both	ICD Code: 58	Date of diagnosis: 57
85	Impingement *(anterior/ posterior (or trigonum syndrome)/anterolateral))*	Side affected:	2	Right	53	Left	54	Both	ICD Code: 55	Date of diagnosis: 56
86	Tendonitis *(achilles/peroneal/ posterior tibial)*	Side affected:	52	Right	51	Left	50	Both	ICD Code: 49	Date of diagnosis: 48
87	Retrocalcaneal bursitis	Side affected:	3	Right	44	Left	45	Both	ICD Code: 46	Date of diagnosis: 47
88	Achilles tendon rupture	Side affected:	43	Right	42	Left	41	Both	ICD Code: 40	Date of diagnosis: 39
89	Osteoarthritis of the ankle	Side affected:	4	Right	35	Left	36	Both	ICD Code: 37	Date of diagnosis: 38
90	Avascular necrosis, talus	Side affected:	34	Right	33	Left	32	Both	ICD Code: 31	Date of diagnosis: 30
91	Ankle joint replacement	Side affected:	5	Right	26	Left	27	Both	ICD Code: 28	Date of diagnosis: 29
92	Ankylosis of ankle, subtalar or tarsal joint	Side affected:	25	Right	24	Left	23	Both	ICD Code: 22	Date of diagnosis: 21

93 Other *(specify)*

Other diagnosis #1: 104

Side affected: 6 Right 17 Left 18 Both ICD Code: 19 Date of diagnosis: 20

Other diagnosis #2: 103

Side affected: 16 Right 15 Left 14 Both ICD Code: 13 Date of diagnosis: 12

Other diagnosis #3: 102

Side affected: 7 Right 8 Left 9 Both ICD Code: 10 Date of diagnosis: 11

SECTION I - DIAGNOSIS *(Continued)*

1C. COMMENTS *(if any):*

108

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

125 YES 124 NO 123 N/A

SECTION II - MEDICAL HISTORY

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

107

2B. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE ANKLE?

114 YES 113 NO

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

109

2C. 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)*?

111 YES 112 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

Ankle	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 ANKLE All Normal	Plantar Flexion (normal endpoint = 45 degrees)	133 138 Not indicated 134 Not able to perform	132
	Dorsiflexion (normal endpoint = 20 degrees)	137 135 Not indicated 136 Not able to perform	131
LEFT ANKLE All Normal	Plantar Flexion (normal endpoint = 45 degrees)	121 116 Not indicated 120 Not able to perform	126
	Dorsiflexion (normal endpoint = 20 degrees)	117 119 Not indicated 118 Not able to perform	127

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

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

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

128

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

122

SECTION IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

4A. POST-TEST ROM MEASUREMENTS

Ankle	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 ANKLE	166 Yes If yes, perform repetitive-use testing 167 No If no, provide reason below, then proceed to Section 5 170	169 Yes 168 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.	Plantar Flexion	165
			Dorsiflexion	164
LEFT ANKLE	149 Yes If yes, perform repetitive-use testing 148 No If no, provide reason below, then proceed to Section 5 145	146 Yes 147 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.	Plantar Flexion	150
			Dorsiflexion	151

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

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

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

152

SECTION V - PAIN

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

Ankle	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 ANKLE	171 Yes 172 No	173 Yes *(you will be asked to further describe these limitations in Section 6 below)* 174 No	175
LEFT ANKLE	158 Yes 155 No	156 Yes *(you will be asked to further describe these limitations in Section 6 below)* 157 No	159

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

Ankle	Is there pain when the joint is used in weight-bearing or non weight-bearing? *(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 ANKLE	180 Yes 179 No	178 Yes *(you will be asked to further describe these limitations in Section 6 below)* 177 No	176
LEFT ANKLE	141 Yes 144 No	143 Yes *(you will be asked to further describe these limitations in Section 6 below)* 142 No	140

5C. LOCALIZED TENDERNESS OR PAIN ON PALPATION

Ankle	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 ANKLE	181 Yes 182 No	183
LEFT ANKLE	161 Yes 160 No	162

5D. COMMENTS, IF ANY:

163

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)*:

224 No functional loss for left lower extremity attributable to claimed condition

186 No functional loss for right lower extremity attributable to claimed condition

187	Less movement than normal *(due to ankylosis, limitation or blocking, adhesions, tendon-tie-ups, contracted scars, etc.)*	221 Right	251 Left	222 Both
223	More movement than normal *(from flail joints, resections, nonunion of fractures, relaxation of ligaments, etc..)*	220 Right	250 Left	219 Both
185	Weakened movement *(due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.)*	217 Right	249 Left	218 Both
184	Excess fatigability	216 Right	248 Left	215 Both
231	Incoordination, impaired ability to execute skilled movements smoothly	213 Right	247 Left	214 Both
230	Pain on movement	212 Right	246 Left	211 Both
229	Swelling	209 Right	245 Left	210 Both
228	Deformity	208 Right	244 Left	207 Both
227	Atrophy of disuse	205 Right	188 Left	206 Both
189	Instability of station	203 Right	204 Left	202 Both
201	Disturbance of locomotion	199 Right	190 Left	200 Both
191	Interference with sitting	197 Right	198 Left	196 Both
195	Interference with standing	193 Right	192 Left	194 Both

226 Other, describe:

225

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.

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

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

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

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

Ankle	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 ANKLE	256 Yes 257 No	Plantar Flexion	252 ____ 253 Est. ROM is not feasible	258
		Dorsiflexion	255 ____ 254 Est. ROM is not feasible	
LEFT ANKLE	239 Yes 238 No	Plantar Flexion	237 ____ 236 Est. ROM is not feasible	240
		Dorsiflexion	234 ____ 235 Est. ROM is not feasible	

CONTRIBUTING FACTORS OF DISABILITY NOT ASSOCIATED WITH LIMITATION OF MOTION

6D. 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 ANKLE 260 YES 261 NO IF YES, DESCRIBE:

259

LEFT ANKLE 242 YES 241 NO IF YES, DESCRIBE:

243

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

Ankle	Flexion	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 ANKLE All Normal	Plantar Flexion	/5 263	266 Yes 267 No	269 Yes 268 No	264
	Dorsiflexion	/5 262			
LEFT ANKLE All Normal	Plantar Flexion	/5 308	307 Yes 306 No	304 Yes 305 No	302
	Dorsiflexion	/5 301			

7B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

270 YES 271 NO

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

272 YES 277 NO IF NO, PROVIDE RATIONALE:

278

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:

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

311

CIRCUMFERENCE OF MORE NORMAL SIDE: 310 cm

CIRCUMFERENCE OF ATROPHIED SIDE: 309 cm

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

274

CIRCUMFERENCE OF MORE NORMAL SIDE: 273 cm

CIRCUMFERENCE OF ATROPHIED SIDE: 275 cm

7C. COMMENTS, IF ANY:

279

SECTION VIII - ANKYLOSIS

COMPLETE THIS SECTION IF VETERAN HAS ANKYLOSIS OF THE ANKLE.

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

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

RIGHT SIDE:

289 In plantar flexion
If checked, provide degrees: 288
287 In dorsiflexion
If checked, provide degrees: 281
286 With an abduction deformity
285 With an inversion deformity
284 With an eversion deformity
283 In good weight-bearing position
282 In poor weight-bearing position
297 No ankylosis

LEFT SIDE:

290 In plantar flexion
If checked, provide degrees: 291
292 In dorsiflexion
If checked, provide degrees: 300
293 With an abduction deformity
294 With an inversion deformity
295 With an eversion deformity
296 In good weight-bearing position
299 In poor weight-bearing position
298 No ankylosis

8B. COMMENTS, IF ANY:

280

SECTION IX - JOINT STABILITY

Ankle	Is ankle instability or dislocation suspected?	If yes, complete the following:	
		Anterior Drawer Test Is there laxity compared with opposite side?	Talar Tilt Test *(inversion/eversion stress)* Is there laxity compared with opposite side?
RIGHT ANKLE	359 YES 358 NO	350 YES 349 NO 348 UNABLE TO TEST	353 YES 352 NO
LEFT ANKLE	341 YES 342 NO	355 YES 356 NO 357 UNABLE TO TEST	351 YES 354 NO

SECTION X - ADDITIONAL COMMENTS

10. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD "SHIN SPLINTS", STRESS FRACTURES, ACHILLES TENDONITIS, ACHILLES TENDON RUPTURE, MALUNION OF CALCANEUS *(os calcis)* OR TALUS *(astragalus)*, OR HAS THE VETERAN HAD A TALECTOMY *(astragalectomy)*?

343 YES 345 NO

IF YES, INDICATE CONDITION AND COMPLETE THE APPROPRIATE SECTIONS BELOW:

344 SHIN SPLINTS *(medical tibial stress syndrome)*

INDICATE SIDE AFFECTED: 337 RIGHT 313 LEFT 336 BOTH

DOES THIS CONDITION AFFECT ROM OF ANKLE?

346 YES *(If "yes," complete ROM section of ankle on this DBQ)*

347 NO

DOES THIS CONDITION AFFECT ROM OF KNEE?

339 YES *(If "yes," complete VA Form 21-0960M-9 Knee and Lower Leg Conditions)*

338 NO

DESCRIBE CURRENT SYMPTOMS:

360

340 STRESS FRACTURE OF THE LOWER LEG

INDICATE SIDE AFFECTED: 333 RIGHT 335 LEFT 334 BOTH

DESCRIBE CURRENT SYMPTOMS:

361

329 ACHILLES TENDONITIS OR ACHILLES TENDON RUPTURE

INDICATE SIDE AFFECTED: 332 RIGHT 330 LEFT 331 BOTH

DESCRIBE CURRENT SYMPTOMS:

314

327 MALUNION OF CALCANEOUS *(os calcis)* OR TALUS *(astragalus)*

INDICATE SEVERITY AND SIDE AFFECTED:

328 MODERATE DEFORMITY 324 RIGHT 326 LEFT 325 BOTH

320 MARKED DEFORMITY 323 RIGHT 321 LEFT 322 BOTH

318 TALECTOMY

INDICATE SIDE AFFECTED: 315 RIGHT 317 LEFT 316 BOTH

DESCRIBE CURRENT SYMPTOMS:

319

SECTION XI - SURGICAL PROCEDURES

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

RIGHT SIDE:

421 TOTAL ANKLE JOINT REPLACEMENT
DATE OF SURGERY: 419
RESIDUALS:
420 None
424 Intermediate degrees of residual weakness, pain or limitation of motion
423 Chronic residuals consisting of severe painful motion or weakness
422 Other, describe:

417

426 ARTHROSCOPIC OR OTHER ANKLE SURGERY
TYPE OF SURGERY: 415
DATE OF SURGERY: 418

425 RESIDUALS OF ARTHROSCOPIC OR OTHER ANKLE SURGERY
DESCRIBE RESIDUALS:

416

LEFT SIDE:

380 TOTAL ANKLE JOINT REPLACEMENT
DATE OF SURGERY: 382
RESIDUALS:
381 None
377 Intermediate degrees of residual weakness, pain or limitation of motion
378 Chronic residuals consisting of severe painful motion or weakness
379 Other, describe:

384

375 ARTHROSCOPIC OR OTHER ANKLE SURGERY
TYPE OF SURGERY: 386
DATE OF SURGERY: 383

376 RESIDUALS OF ARTHROSCOPIC OR OTHER ANKLE SURGERY
DESCRIBE RESIDUALS:

385

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

12A. 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?

371 YES 370 NO IF YES, COMPLETE QUESTIONS 12B-12D.

12B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

364 YES 365 NO IF YES, DESCRIBE *(brief summary)*:

362

12C. 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?

366 YES 367 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?

368 YES 369 NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

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

LOCATION: 372 MEASUREMENTS: length 373 cm X width 374 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.

12D. COMMENTS, IF ANY:

363

SECTION XIII - ASSISTIVE DEVICES

13A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

388 YES 413 NO IF YES, IDENTIFY ASSISTIVE DEVICES USED *(check all that apply and indicate frequency):*

405 Wheelchair	Frequency of use:	404 Occasional	403 Regular	402 Constant
389 Brace	Frequency of use:	407 Occasional	411 Regular	412 Constant
401 Crutches	Frequency of use:	400 Occasional	399 Regular	398 Constant
390 Cane	Frequency of use:	395 Occasional	396 Regular	397 Constant
394 Walker	Frequency of use:	393 Occasional	392 Regular	391 Constant
406 Other: 414	Frequency of use:	410 Occasional	409 Regular	408 Constant

13B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

387

SECTION XIV - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

14A. DUE TO THE VETERAN'S ANKLE CONDITIONS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)*

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

430 NO

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES: 428 RIGHT LOWER 429 LEFT LOWER

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

427

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 XV - 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.

15A. HAVE IMAGING STUDIES OF THE ANKLE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

444 YES 443 NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

439 YES 440 NO IF YES, INDICATE ANKLE: 445 RIGHT 437 LEFT 438 BOTH

15B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS OR RESULTS?

441 YES 442 NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

446

15C. IS THERE OBJECTIVE EVIDENCE OF CREPITUS?

434 YES 433 NO IF YES, INDICATE ANKLE: 432 RIGHT 436 LEFT 435 BOTH

15D. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

447

SECTION XVI - 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.

16. 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.)*?

450 YES 449 NO IF YES, DESCRIBE THE FUNCTIONAL IMPACT OF EACH CONDITION, PROVIDING ONE OR MORE EXAMPLES:

448

SECTION XVII - REMARKS

17. REMARKS, IF ANY:

451

SECTION XVIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

18A. PHYSICIAN'S SIGNATURE	18B. PHYSICIAN'S PRINTED NAME	18C. DATE SIGNED
458	455	454

18D. PHYSICIAN'S PHONE NUMBER	18E. PHYSICIAN'S MEDICAL LICENSE NUMBER	18F. PHYSICIAN'S ADDRESS
457	456	453

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 452 _____

(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.