OMB Control No. 2900-0779
Respondent Burden: 30 minutes

AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE) 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 BEFORE COMPLETING FORM.

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

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE AMYOTROPHIC LATERAL SCLEROSIS (ALS)?

☐ YES ☐ NO *(If "Yes," complete Item 1B)*

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO AMYOTROPHIC LATERAL SCLEROSIS

Diagnosis # 1 -	ICD code -	Date of diagnosis -
Diagnosis # 2 -	ICD code -	Date of diagnosis -
Diagnosis # 3 -	ICD code -	Date of diagnosis -

1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO AMYOTROPHIC LATERAL SCLEROSIS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S ALS:

2B. DOMINANT HAND

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS

3A. DOES THE VETERAN HAVE ANY MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," report under strength testing in Section IV, Neurologic Exam, Item 4C.)

3B. DOES THE VETERAN HAVE ANY PHARYNX AND/OR LARYNX AND/OR SWALLOWING CONDITIONS DUE TO ALS?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ CONSTANT INABILITY TO COMMUNICATE BY SPEECH
- ☐ SPEECH NOT INTELLIGIBLE OR INDIVIDUAL IS APHONIC
- ☐ PARALYSIS OF SOFT PALATE WITH SWALLOWING DIFFICULTY *(nasal regurgitation)* AND SPEECH IMPAIRMENT
- ☐ HOARSENESS
- ☐ MILD SWALLOWING DIFFICULTIES
- ☐ MODERATE SWALLOWING DIFFICULTIES
- ☐ SEVERE SWALLOWING DIFFICULTIES, PERMITTING PASSAGE OF LIQUIDS ONLY
- ☐ REQUIRES FEEDING TUBE DUE TO SWALLOWING DIFFICULTIES
- ☐ OTHER *(describe)*: ______

3C. DOES THE VETERAN HAVE ANY RESPIRATORY CONDITIONS ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," provide PFT results in Section X, Diagnostic Testing.)

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS *(Continued)*

3D. DOES THE VETERAN HAVE SIGNS AND/OR SYMPTOMS OF SLEEP APNEA ATTRIBUTABLE TO ALS?

NOTE: If signs and/or symptoms of sleep apnea are due to ALS, these symptoms are due to weakness in the palatal, pharyngeal, laryngeal, and/or respiratory musculature. A sleep study is not indicated to report symptoms of sleep apnea that are attributable to ALS.

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ PERSISTENT DAYTIME HYPERSOMNOLENCE
☐ REQUIRES USE OF BREATHING ASSISTANCE DEVICE SUCH AS CONTINUOUS AIRWAY PRESSURE (CPAP) MACHINE
☐ CHRONIC RESPIRATORY FAILURE WITH CARBON DIOXIDE RETENTION OR COR PULMONALE
☐ REQUIRES TRACHEOSTOMY

3E. DOES THE VETERAN HAVE ANY BOWEL FUNCTIONAL CONDITIONS ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ SLIGHT IMPAIRMENT OF SPHINCTER CONTROL, WITHOUT LEAKAGE
☐ CONSTANT SLIGHT IMPAIRMENT OF SPHINCTER CONTROL, OR OCCASIONAL MODERATE LEAKAGE
☐ OCCASIONAL INVOLUNTARY BOWEL MOVEMENTS, NECESSITATING WEARING OF A PAD
☐ EXTENSIVE LEAKAGE AND FAIRLY FREQUENT INVOLUNTARY BOWEL MOVEMENTS
☐ TOTAL LOSS OF BOWEL SPHINCTER CONTROL
☐ CHRONIC CONSTIPATION
☐ OTHER BOWEL IMPAIRMENT *(describe):* ____________________

3F. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING URINE LEAKAGE ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ DOES NOT REQUIRE/DOES NOT USE ABSORBENT MATERIAL
☐ REQUIRES ABSORBENT MATERIAL THAT IS CHANGED LESS THAN 2 TIMES PER DAY
☐ REQUIRES ABSORBENT MATERIAL THAT IS CHANGED 2 TO 4 TIMES PER DAY
☐ REQUIRES ABSORBENT MATERIAL THAT IS CHANGED MORE THAN 4 TIMES PER DAY

3G. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING SIGNS AND/OR SYMPTOMS OF URINARY FREQUENCY ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ DAYTIME VOIDING INTERVAL BETWEEN 2 AND 3 HOURS
☐ DAYTIME VOIDING INTERVAL BETWEEN 1 AND 2 HOURS
☐ DAYTIME VOIDING INTERVAL LESS THAN 1 HOUR
☐ NIGHTTIME AWAKENING TO VOID 2 TIMES
☐ NIGHTTIME AWAKENING TO VOID 3 TO 4 TIMES
☐ NIGHTTIME AWAKENING TO VOID 5 OR MORE TIMES

3H. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING FINDINGS, SIGNS AND/OR SYMPTOMS OF OBSTRUCTED VOIDING ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all signs and symptoms that apply)

☐ HESITANCY

(If checked, is hesitancy marked?)

☐ YES ☐ NO

☐ SLOW OR WEAK STREAM

(If checked, is stream markedly slow or weak?)

☐ YES ☐ NO

☐ DECREASED FORCE OF STREAM

(If checked, is force of stream markedly decreased?)

☐ YES ☐ NO

☐ STRICTURE DISEASE REQUIRING DILATATION 1 TO 2 TIMES PER YEAR
☐ STRICTURE DISEASE REQUIRING PERIODIC DILATATION EVERY 2 TO 3 MONTHS
☐ RECURRENT URINARY TRACT INFECTIONS SECONDARY TO OBSTRUCTION
☐ UROFLOWMETRY PEAK FLOW RATE LESS THAN 10cc/sec
☐ POST VOID RESIDUALS GREATER THAN 150 cc
☐ URINARY RETENTION REQUIRING INTERMITTENT OR CONTINUOUS CATHETERIZATION

3I. DOES THE VETERAN HAVE VOIDING DYSFUNCTION REQUIRING THE USE OF AN APPLIANCE ATTRIBUTABLE TO ALS?

☐ YES ☐ NO *(If "Yes," describe):*

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS *(Continued)*

3J. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT INFECTIONS ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If "Yes," check all of the following treatment modalities that apply)

☐ NO TREATMENT

☐ LONG-TERM DRUG THERAPY

(If checked, list medications used for urinary tract infection and indicate dates for courses of treatment over the past 12 months):

☐ HOSPITALIZATION

(If checked, indicate frequency of hospitalization)

☐ 1 or 2 per year

☐ More than 2 per year

☐ DRAINAGE

(If checked, indicate dates when drainage performed over past 12 months):

☐ OTHER MANAGEMENT/TREATMENT

(If checked, provide description of management/treatment including dates of treatment):

3K. DOES THE VETERAN *(if male)* HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO

(If "Yes," is the erectile dysfunction as likely as not (at least a 50% probability) attributable to ALS?)

☐ YES ☐ NO

(If "No," provide the etiology of the erectile dysfunction):

(If "Yes," is the veteran able to achieve an erection (without medication) sufficient for penetration and ejaculation?)

☐ YES ☐ NO

(If "No," is the veteran able to achieve an erection (with medication) sufficient for penetration and ejaculation?)

☐ YES ☐ NO

SECTION IV - NEUROLOGIC EXAM

4A. SPEECH

☐ NORMAL ☐ ABNORMAL

(If speech is abnormal, describe):

4B. GAIT

☐ NORMAL ☐ ABNORMAL

(If gait is abnormal, describe): (If the Veteran has more than one medical condition contributing to the abnormal gait, identify the condition(s) and describe each condition's contribution to the abnormal gait):

4C. STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

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

Elbow Flexion	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Elbow Extension	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Wrist Flexion	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Wrist Extension	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Grip	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Pinch *(thumb to index finger)*	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Knee Extension	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Ankle Plantar Flexion	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Ankle Dorsiflexion	RIGHT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	LEFT:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

SECTION IV - NEUROLOGIC EXAM *(Continued)*

4D. DEEP TENDON REFLEXES (DTRs) - RATE REFLEXES ACCORDING TO THE FOLLOWING SCALE:

0 - Absent | 2+ Normal | 4+ Increased with clonus

1+ Decreased | 3+ Increased without clonus

Biceps	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Triceps	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Brachioradialis	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Knee	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Ankle	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+

4E. DOES THE VETERAN HAVE MUSCLE ATROPHY ATTRIBUTABLE TO ALS?

☐ YES ☐ NO

(If muscle atrophy is present, indicate location): ____________________

(When possible, provide difference measured in cm between normal and atrophied side, measured at maximum muscle bulk: ________*cm.)*

4F. SUMMARY OF MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES ATTRIBUTABLE TO ALS *(check all that apply):*

Right upper extremity muscle weakness:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ With atrophy	☐ Complete *(no remaining function)*
Left upper extremity muscle weakness:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ With atrophy	☐ Complete *(no remaining function)*
Right lower extremity muscle weakness:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ With atrophy	☐ Complete *(no remaining function)*
Left lower extremity muscle weakness:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ With atrophy	☐ Complete *(no remaining function)*

NOTE: If the Veteran has more than one medical condition contributing to the muscle weakness, identify the condition(s) and describe each condition's contribution to the muscle weakness:

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

5. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO

(If "Yes," describe (brief summary):

SECTION VI - HOUSEBOUND

6. IS THE VETERAN SUBSTANTIALLY CONFINED TO HIS OR HER DWELLING AND THE IMMEDIATE PREMISES *(or if institutionalized, to the ward or clinical areas)?*

☐ YES ☐ NO

(If "Yes," describe how often per day or week and under what circumstances the veteran is able to leave the home or immediate premises): ____________________

(If "Yes," does the veteran have more than one condition contributing to his or her being housebound)

☐ YES ☐ NO

(If "Yes," list conditions and describe how each condition contributes to causing the veteran to be housebound)

PROVIDE CONDITIONS AND DESCRIBE HOW EACH CONDITION CONTRIBUTES TO THE VETERAN BEING HOUSEBOUND

CONDITION # 1 -	DESCRIPTION -
CONDITION # 2 -	DESCRIPTION -
CONDITION # 3 -	DESCRIPTION -
LIST ANY ADDITIONAL CONDITIONS -	DESCRIPTION -
LIST ANY ADDITIONAL CONDITIONS -	DESCRIPTION -
LIST ANY ADDITIONAL CONDITIONS -	DESCRIPTION -
LIST ANY ADDITIONAL CONDITIONS -	DESCRIPTION -
LIST ANY ADDITIONAL CONDITIONS -	DESCRIPTION -

SECTION VII - AID AND ATTENDANCE

7A. DOES THE VETERAN REQUIRE CARE AND/OR ASSISTANCE ON A REGULAR BASIS DUE TO HIS OR HER PHYSICAL AND/OR MENTAL DISABILITIES IN ORDER TO PROTECT HIM OR HERSELF FROM THE HAZARDS AND/OR DANGERS INCIDENT TO HIS OR HER DAILY ENVIRONMENT?

☐ YES ☐ NO

7B. IS THE VETERAN ABLE TO DRESS OR UNDRESS HIM/HERSELF?

☐ YES ☐ NO

7C. DOES THE VETERAN HAVE SUFFICIENT UPPER EXTREMITY COORDINATION AND STRENGTH TO BE ABLE TO FEED HIM/HERSELF?

☐ YES ☐ NO

7D. IS THE VETERAN ABLE TO ATTEND TO THE WANTS OF NATURE?

☐ YES ☐ NO

7E. IS THE VETERAN ABLE TO KEEP HIM OR HERSELF ORDINARILY CLEAN AND PRESENTABLE?

☐ YES ☐ NO

7F. IS THE VETERAN ABLE TO TAKE HIS OR HER PRESCRIPTION MEDICATIONS IN A TIMELY MANNER AND WITH ACCURATE DOSAGE WITHOUT ASSISTANCE?

☐ YES ☐ NO

7G. DOES THE VETERAN NEED FREQUENT ASSISTANCE FOR ADJUSTMENT OF ANY SPECIAL PROSTHETIC OR ORTHOPEDIC APPLIANCE(S)?

☐ YES ☐ NO

(If "Yes," describe (brief summary): ______

7H. DOES THE VETERAN'S CONDITION(S) REQUIRE THAT THE VETERAN REMAIN IN BED *(this does not include conditions for which the veteran has voluntarily taken to his/her bed or that a physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure)*?

☐ YES ☐ NO

(If "Yes," is it due to the service-connected disabling condition(s))

☐ YES ☐ NO

7I. IS THE VETERAN BLIND?

☐ YES ☐ NO

(If "Yes," is it due to ALS?)

☐ YES ☐ NO

7J. DOES THE VETERAN REQUIRE HEALTH-CARE SERVICES SUCH AS PHYSICAL THERAPY, ADMINISTRATION OF INJECTIONS, PLACEMENT OF INDWELLING CATHETERS, CHANGING OF STERILE DRESSINGS, AND/OR LIKE FUNCTIONS WHICH REQUIRE PROFESSIONAL HEALTH-CARE TRAINING OR THE REGULAR SUPERVISION OF A TRAINED HEALTH-CARE PROFESSIONAL TO PERFORM?

☐ YES ☐ NO

(If "Yes," describe (brief summary): ______

SECTION VIII - ASSISTIVE DEVICES AND REMAINING FUNCTION OF THE EXTREMITIES

8A. DOES THE VETERAN USE ANY ASSISTIVE DEVICE(S) AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

☐ YES ☐ NO

(If "Yes," identify assistive device(s) used (check all that apply and indicate frequency))

Device	Frequency of use			
☐ WHEELCHAIR	Frequency of use:	☐ occasional	☐ regular	☐ constant
☐ BRACE(S)	Frequency of use:	☐ occasional	☐ regular	☐ constant
☐ CRUTCH(ES)	Frequency of use:	☐ occasional	☐ regular	☐ constant
☐ CANE(S)	Frequency of use:	☐ occasional	☐ regular	☐ constant
☐ WALKER	Frequency of use:	☐ occasional	☐ regular	☐ constant
☐ OTHER: ______	Frequency of use:	☐ occasional	☐ regular	☐ constant

8B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

8C. DUE TO ALS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTION REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)*

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

☐ NO

(If "Yes," indicate extremity(ies) (check all extremities for which this applies)):

☐ RIGHT UPPER ☐ LEFT UPPER ☐ RIGHT LOWER ☐ LEFT LOWER

NOTE: For each checked extremity, describe loss of effective function, identify the condition causing loss of function, and provide specific examples *(brief summary):*

SECTION IX - FINANCIAL RESPONSIBILITY

9. IN YOUR JUDGMENT, IS THE VETERAN ABLE TO MANAGE HIS/HER BENEFIT PAYMENTS IN HIS/HER OWN BEST INTEREST, OR ABLE TO DIRECT SOMEONE ELSE TO DO SO?

☐ YES ☐ NO

SECTION X - DIAGNOSTIC TESTING

NOTE - If pulmonary function testing (PFT) is indicated due to respiratory disability, and results are in the medical record and reflect the veteran's current respiratory function, repeat testing is not required. DLCO and bronchodilator testing is not indicated for a restrictive respiratory disability such as that caused by muscle weakness due to ALS.

10A. HAVE PULMONARY FUNCTION TESTING (PFTs) BEEN PERFORMED?

☐ YES ☐ NO

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

FEV1: ______________ % predicted Date of test: __________________

FEV1/FVC: ______________ % predicted Date of test: __________________

FEV: ______________ % predicted Date of test: __________________

10B. IF PFTs HAVE BEEN PERFORMED, IS THE FLOW-VOLUME LOOP COMPATIBLE WITH UPPER AIRWAY OBSTRUCTION?

☐ YES ☐ NO

10C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

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

SECTION XI - FUNCTIONAL IMPACT AND REMARKS

11. DOES THE VETERAN'S ALS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of the veteran's ALS, providing one or more examples)*

12. REMARKS *(If any)*

SECTION XII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

13A. PHYSICIAN'S SIGNATURE	13B. PHYSICIAN'S PRINTED NAME	13C. DATE SIGNED

13D. PHYSICIAN'S PHONE AND FAX NUMBER	13E. PHYSICIAN'S MEDICAL LICENSE NUMBER	13F. PHYSICIAN'S ADDRESS

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 ______________________________________

(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, 58VA21/22/28, 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 low 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 a 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.