OMB Approved No. 2900-XXXX
Respondent Burden: 15 minutes

Department of Veterans Affairs

PARKINSON'S DISEASE DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING FORM.

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

NOTE TO PHYSICIAN - The veteran has applied to the Department of Veterans Affairs (VA) for disability benefits. Please complete this questionnaire, which VA needs for review of the veteran's application.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH PARKINSON'S DISEASE?	1B. DATE OF DIAGNOSIS
☐ YES (If "Yes," please provide date of diagnosis) ☐ NO (If "No," please skip to Section VI)	

SECTION II - MOTOR MANIFESTATIONS

2. MOTOR MANIFESTATIONS DUE TO PARKINSON'S OR ITS TREATMENT (Check all that apply)

MOTOR MANIFESTATIONS	NONE	MILD	MODERATE	SEVERE
STOOPED POSTURE				
BALANCE IMPAIRMENT				
TREMOR (Characteristic hand shaking, "pill-rolling")				
BRADYKINESIA OR SLOWED MOTION (Difficulty initiating movement, "freezing," short shuffling steps)				
LOSS OF AUTOMATIC MOVEMENTS (Such as blinking, smiling, leading to fixed gaze, typical Parkinson's facies)				
SPEECH CHANGES (Monotone, slurring words, soft or rapid speech)				
MUSCLE RIGIDITY AND STIFFNESS				

EXTREMITIES FUNCTIONALLY AFFECTED BY PARKINSON'S DISEASE:

☐ NONE ☐ RIGHT UPPER ☐ LEFT UPPER ☐ RIGHT LOWER ☐ LEFT LOWER

SECTION III - MENTAL MANIFESTATIONS

3. MENTAL MANIFESTATIONS DUE TO PARKINSON'S OR ITS TREATMENT (Check all that apply)

MENTAL MANIFESTATIONS	NONE	MILD	MODERATE	SEVERE
DEPRESSION				
COGNITIVE IMPAIRMENT OR DEMENTIA				

SECTION IV - ADDITIONAL MANIFESTATIONS/COMPLICATIONS

4. ADDITIONAL MANIFESTATIONS/COMPLICATIONS DUE TO PARKINSON'S OR ITS TREATMENT (Check all that apply)

ADDITIONAL MANIFESTATIONS/COMPLICATIONS	NONE	MILD	MODERATE	SEVERE
LOSS OF SENSE OF SMELL ☐ PARTIAL ☐ COMPLETE				
SLEEP DISTURBANCE (Insomnia or daytime "sleep attacks")				
DIFFICULTY CHEWING/SWALLOWING				
URINARY PROBLEMS (Incontinence or urinary retention) - (Indicate "None" or, if absorbent material required due to incontinence, specify pads/day: ☐ 0-1 ☐ 2-4 ☐ MORE THAN 4 OR USE OF APPLIANCE				
CONSTIPATION (DUE TO SLOWING OF GI TRACT OR SECONDARY TO PARKINSON'S MEDICATIONS)				
SEXUAL DYSFUNCTION				*(PRECLUDES INTERCOURSE)*
OTHER MANIFESTATIONS/COMPLICATIONS (Specify				
OTHER MANIFESTATIONS/COMPLICATIONS (Specify				
OTHER MANIFESTATIONS/COMPLICATIONS (Specify				

5. FINANCIAL RESPONSIBILITY - 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 V - REMARKS

6. REMARKS (Including impact of Parkinson's on veteran's ability to work)

SECTION VI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

7A. PHYSICIAN'S SIGNATURE	7B. PHYSICIAN'S PRINTED NAME	7C. DATE SIGNED

7D. PHYSICIAN'S PHONE NUMBER	7E. PHYSICIAN'S MEDICAL LICENSE NUMBER	7F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain additional medical information, including an examination, 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.)

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 15 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.