

**Department of Veterans Affairs** **ELBOW AND FOREARM 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
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**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 AN ELBOW OR FOREARM CONDITION?

YES  NO (If "Yes," complete Item 1C) (If "No," complete Item 1B)

1B. PROVIDE RATIONALE (e.g. veteran does not currently have any known elbow or forearm condition)

1C. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO ELBOW AND FOREARM CONDITIONS

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH

1D. IF ADDITIONAL DIAGNOSIS PERTAINING TO ELBOW AND FOREARM CONDITION, LIST USING ABOVE FORMAT

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S ELBOW AND FOREARM CONDITION (brief summary)

2B. DOMINANT HAND

RIGHT  LEFT  AMBIDEXTROUS

2C. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE AFFECTED JOINT(S)?

YES  NO (If "Yes," document the veteran's description of the impact of flare-ups in his or her own words)

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

3. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. REPORT INITIAL MEASUREMENTS BELOW:

**A. RIGHT ELBOW ROM**

Check box at which flexion ends (normal endpoint is 145 degrees):

0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110  115  120  125  130  135  140  145 or greater

Check box at which extension ends:

0 or any degree of hyperextension (no limitation of extension)

Unable to fully extend; extension ends at:

5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110 or greater

**B. LEFT ANKLE ROM**

Check box at which flexion ends (normal endpoint is 145 degrees):

0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110  115  120  125  130  135  140  145 or greater

Check box at which extension ends:

0 or any degree of hyperextension (no limitation of extension)

Unable to fully extend; extension ends at:

5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110 or greater

**C.** If ROM does not conform to the normal range of motion identified above but is normal for this veteran (for reasons other than an elbow condition, such as age, body habitus, neurologic disease), explain:

**SECTION IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING**

**NOTE - FOR VA PURPOSES, REPETITIVE - USE TESTING MUST ALSO BE PERFORMED. THE VA HAS DETERMINED THAT 3 REPETITIONS, AT MINIMUM, CAN SERVE AS A REPRESENTATIVE TEST FOR THE EFFECT OF REPETITIVE USE. FOLLOWING INITIAL ROM ASSESSMENT, THE CLINICIAN MUST PERFORM REPETITIVE - USE TESTING AND REPORT POST - TEST MEASUREMENTS.**

**4. ROM MEASUREMENTS AFTER REPETITIVE USE TESTING**

**A. RIGHT ELBOW POST-TEST ROM**

Check box at which post-test flexion ends:

- 0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110  115  120  125  130  135  140  145 or greater

Check box at which post-test extension ends

- 0 or any degree of hyperextension (*no limitation of extension*)

Unable to fully extend; extension ends at:

- 5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110 or greater

**B. LEFT ELBOW POST-TEST ROM**

Check box at which post-test flexion ends:

- 0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110  115  120  125  130  135  140  145 or greater

Check box at which post-test extension ends

- 0 or any degree of hyperextension (*no limitation of extension*)

Unable to fully extend; extension ends at:

- 5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110 or greater

**SECTION V - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM**

5A. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE ELBOW AND FOREARM?

- YES  NO

5B. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE ELBOW AND FOREARM FOLLOWING REPETITIVE-USE TESTING?

- YES  NO

5C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE ELBOW AND FOREARM AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW (*check all that apply and indicate side affected*):

- No functional loss for right upper extremity  
 No functional loss for left upper extremity  
 Less movement than normal  Right  Left  Both  
 More movement than normal  Right  Left  Both  
 Weakened movement  Right  Left  Both  
 Excess fatigability  Right  Left  Both  
 Incoordination, impaired ability to execute skilled movements smoothly  Right  Left  Both  
 Pain on movement  Right  Left  Both  
 Swelling  Right  Left  Both

**SECTION VI - PAINFUL MOTION, TENDERNESS AND STRENGTH TESTING**

6A. IS THERE OBJECTIVE EVIDENCE OF PAINFUL MOTION FOR EITHER ELBOW (*evidenced by visible behavior, such as facial expression, wincing, etc.*)?

- YES  NO (*If "Yes," indicate side affected*):  Right  Left  Both

6B. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN TO PALPATION FOR JOINTS/SOFT TISSUE OF EITHER ELBOW OR FOREARM?

- YES  NO (*If "Yes," indicate side affected*):  Right  Left  Both

6C. STRENGTH TESTING - 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

**SECTION VII - ADDITIONAL CONDITIONS**

7. DOES THE VETERAN HAVE ANKYLOSIS OF THE ELBOW JOINT, FLAIL JOINT, JOINT FRACTURE AND/OR IMPAIRMENT OF SUPINATION OR PRONATION?

YES  NO

(If "Yes," complete the questions below):

A. Does the veteran have ankylosis of the elbow?

YES  NO (If "Yes," indicate side affected and severity):

- At an angle between 90 and 70 degrees  Right  Left  Both
- At an angle of more than 90 degrees  Right  Left  Both
- At an angle between 70 and 50 degrees  Right  Left  Both
- At an angle of less than 50 degrees  Right  Left  Both
- Complete loss of supination or pronation  Right  Left  Both

B. Does the veteran have flail joint of the elbow?

YES  NO (If "Yes," indicate side affected):  Right  Left  Both

C. Does the veteran have interarticular fracture (joint fracture or humeral fracture) with marked varus or valgus deformity?

YES  NO (If "Yes," indicate side affected):  Right  Left  Both

D. Does the veteran have interarticular fracture (joint fracture) with ununited fracture of the head of the radius?

YES  NO (If "Yes," indicate side affected):  Right  Left  Both

E. Does the veteran have impairment of supination or pronation?

YES  NO (If "Yes," indicate severity and side affected)

- Supination limited to 30 degrees or less  Right  Left  Both
- Limited pronation with motion lost beyond the last quarter of the arc; hand does not approach full pronation  Right  Left  Both
- Limited pronation with motion lost beyond the middle of the arc  Right  Left  Both
- Hand is fixed near the middle of the arc or moderate pronation due to bone fusion  Right  Left  Both
- Hand is fixed in full pronation due to bone fusion  Right  Left  Both
- Hand is fixed in supination or hyperpronation due to bone fusion  Right  Left  Both

**SECTION VIII - JOINT REPLACEMENT AND/OR OTHER SURGICAL PROCEDURES**

8A. HAS THE VETERAN HAD A TOTAL ELBOW JOINT REPLACEMENT?

YES  NO (If "Yes," indicate side and severity of residuals)

Right elbow

Date of surgery: \_\_\_\_\_

Residuals:

- None
- Intermediate degrees of residual weakness, pain and/or limitation of motion
- Chronic residuals consisting of severe painful motion and/or weakness
- Other, describe: \_\_\_\_\_

Left elbow

Date of surgery: \_\_\_\_\_

Residuals:

- None
- Intermediate degrees of residual weakness, pain and/or limitation of motion
- Chronic residuals consisting of severe painful motion and/or weakness
- Other, describe: \_\_\_\_\_

8B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER ELBOW SURGERY?

YES  NO (If "Yes," indicate side affected)

Right  Left  Both

Date of surgery: \_\_\_\_\_

8C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER ELBOW SURGERY?

YES  NO (If "Yes," indicate side affected)

Right  Left  Both

If "Yes," describe symptoms:

**SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS**

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

YES  NO

(If "Yes," describe):

**NOTE** - In all forearm injuries, if there are impaired finger movements due to tendon, muscle or nerve injuries, also complete the appropriate disability questionnaire(s), such as the VA Form 21-0960M-7, Hand and Finger Disability Benefits Questionnaire, the VA Form 21-0960C-10, Peripheral Nerve Conditions Disability Benefits Questionnaire, and the VA Form 21-0960M-10, Muscle Injuries Disability Benefits Questionnaire.

**SECTION X - ASSISTIVE DEVICES AND REMAINING FUNCTION OF THE EXTREMITIES**

10A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES?

YES  NO

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

Brace(s) Frequency of use:  Occasional  Regular  Constant  
 Other: \_\_\_\_\_ Frequency of use:  Occasional  Regular  Constant

(If "Yes," identify and describe each condition(s) causing the need for assistive device(s)):

10B. DUE TO THE SERVICE-CONNECTED DISABLING CONDITION(S), 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 PROSTHESIS? (*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 prosthesis 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

Describe diminished function of each indicated extremity:

**SECTION XI - DIAGNOSTIC TESTING**

**NOTE** - The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are indicated, even if arthritis has worsened.

11A. HAVE IMAGING STUDIES OF THE ELBOW BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO

(If "Yes," is arthritis documented?)

YES  NO

(If "Yes," indicate elbow)

Right  Left  Both

11B. 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 XII - FUNCTIONAL IMPACT AND REMARKS**

12. DOES THE VETERAN'S ELBOW/FOREARM CONDITION IMPACT HIS OR HER ABILITY TO WORK?

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

13. REMARKS (If any)

**SECTION XIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

14A. PHYSICIAN'S SIGNATURE

14B. PHYSICIAN'S PRINTED NAME

14C. DATE SIGNED

14D. PHYSICIAN'S PHONE NUMBER

14E. PHYSICIAN'S MEDICAL LICENSE NUMBER

14F. 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](http://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](http://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.