OMB Approved No. 2900-XXXX
Respondent Burden: 30 minutes

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

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 A WRIST 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 wrist conditions)*

1C. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO WRIST CONDITIONS

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH

1D. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO WRIST CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

A. Right wrist ROM

Check box at which palmar flexion ends *(endpoint of palmar flexion 80 degrees):*

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45
☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 or greater

Check box at which dorsiflexion *(extension)* ends *(endpoint of dorsiflexion (extension) 70 degrees):*

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35
☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 or greater

B. Left wrist ROM

Check box at which palmar flexion ends *(endpoint of palmar flexion 80 degrees):*

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45
☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 or greater

Check box at which dorsiflexion *(extension)* ends *(endpoint of dorsiflexion (extension) 70 degrees):*

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35
☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 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 a wrist 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.

4A. IS VETERAN ABLE TO PERFORM REPETITIVE-USE TESTING WITH 3 REPETITIONS?

☐ YES ☐ NO

If "No," provide reason:

If "No," skip to section 6)

If veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

4B. RIGHT WRIST POST-TEST ROM

Check box at which palmar flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 or greater

Check box at which dorsiflexion (extension) ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ 55 ☐ 60 ☐ 65 ☐ 70 or greater

4C. LEFT WRIST POST-TEST ROM

Check box at which palmar flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 or greater

Check box at which dorsiflexion (extension) ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ 55 ☐ 60 ☐ 65 ☐ 70 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 WRIST?

☐ YES ☐ NO

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

☐ YES ☐ NO

5C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE WRIST 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
☐ DEFORMITY	☐ Right	☐ Left	☐ Both
☐ ATROPHY OF DISUSE	☐ Right	☐ Left	☐ Both

SECTION VI - PAINFUL MOTION, TENDERNESS AND STRENGTH TESTING

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

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

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

☐ YES ☐ NO *(If "Yes," 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

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

SECTION VII - ANKYLOSIS

7. IS THERE ANKYLOSIS OF EITHER WRIST JOINT?

☐ YES ☐ NO

(If "Yes," indicate severity and side affected):

Favorable in 20 degree to 30 degree dorsiflexion	☐ Right	☐ Left	☐ Both
Any other position, except favorable	☐ Right	☐ Left	☐ Both
Unfavorable, in any degree of palmar flexion	☐ Right	☐ Left	☐ Both
Unfavorable, with ulnar or radial deviation	☐ Right	☐ Left	☐ Both
Extremely unfavorable	☐ Right	☐ Left	☐ Both

SECTION VIII - JOINT REPLACEMENT AND/OR OTHER SURGICAL PROCEDURES

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

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

☐ Right wrist

(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 wrist

(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 WRIST SURGERY?

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

(Date and type of surgery):

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

☐ YES ☐ NO *(If "Yes," 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 WRIST-RELATED PERTINENT COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS NOT ALREADY ADDRESSED?

☐ YES ☐ NO

(If "Yes," describe): _____

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 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 WRIST BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," is arthritis documented?)

☐ YES ☐ NO

(If "Yes," indicate wrist)

☐ 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 WRIST CONDITION IMPACT HIS OR HER ABILITY TO WORK?

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

13. REMARKS *(If any)*

SECTION XVII - 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 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.