

**Department of Veterans Affairs** **HAND AND FINGER 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 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 NOW HAVE OR HAS HE/SHE EVER HAD A HAND OR FINGER CONDITION?  
 YES  NO (If "Yes," provide only diagnoses that pertain to hand and finger conditions in Item B):

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO HAND AND FINGER CONDITION(S):

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

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HAND AND FINGER CONDITIONS, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S HAND OR FINGER CONDITION(S) (Brief summary):

2B. DOMINANT HAND  
 Right  Left  Ambidextrous

2C. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE HAND?  
 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**

**NOTE:** Measure ROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the measurements, document the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

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 Section IV.

3A. IS THERE LIMITATION OF MOTION OR EVIDENCE OF PAINFUL MOTION FOR ANY FINGERS AND/OR THUMBS?  
 YES  NO  
 If "No," skip to Section IV  
 If "Yes," indicate digit(s) affected: (check all that apply)  
 Right:  Thumb  Index finger  Long finger  Ring finger  Little finger  
 Left:  Thumb  Index finger  Long finger  Ring finger  Little finger

3B. ABILITY TO OPPOSE THUMB: Is there a gap between the thumb pad and the fingers?  
 YES  NO  
 If "Yes," indicate distance of gap and side affected:  
 Less than 1 inch (2.5cm.)  Right  Left  Both  
 1 to 2 inches (2.5 to 5.1 cm.)  Right  Left  Both  
 More than 2 inches (5.1 cm.)  Right  Left  Both  
 Select where objective evidence of painful motion begins:  
 No objective evidence of painful motion  
 Pain begins at gap of less than 1 inch (2.5 cm.)  Right  Left  Both  
 Pain begins at gap of 1 to 2 inches (2.5 to 5.1 cm.)  Right  Left  Both  
 Pain begins at gap of more than 2 inches (5.1 cm.)  Right  Left  Both

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

3C. FINGER FLEXION: Is there a gap between any fingertips and the proximal transverse crease of the palm or evidence of painful motion in attempting to touch the palm with the fingertips?

YES  NO

If "Yes," indicate the gap:

Gap less than 1 inch (2.5 cm) (Indicate fingers affected (check all that apply)):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

Gap 1 inch (2.5 cm) or more (Indicate fingers affected (check all that apply)):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

Painful motion begins at a gap of less than 1 inch (2.5 cm.)

(Indicate fingers affected (check all that apply)):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

Painful motion begins at a gap of 1 inch (2.5 cm.) or more

(Indicate fingers affected (check all that apply)):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

3D. FINGER EXTENSION: Is there limitation of extension or evidence of painful motion for the index finger and/or long finger?

YES  NO

If "Yes," indicate limitation of extension:

Extension limited by no more than 30 degrees (unable to extend finger fully, extension limited to between 0 and 30 degrees of flexion)

Indicate fingers affected (check all that apply):

Right:  Index finger  Long finger

Left:  Index finger  Long finger

Extension limited by more than 30 degrees (unable to extend finger fully, extension limited to 31 degrees or more of flexion)

Indicate fingers affected (check all that apply):

Right:  Index finger  Long finger

Left:  Index finger  Long finger

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

Painful motion begins at extension of no more than 30 degrees (unable to extend finger fully, painful extension begins between 0 and 30 degrees of flexion)

(Indicate fingers affected (check all that apply)):

Right:  Index finger  Long finger

Left:  Index finger  Long finger

Painful motion begins at extension of more than 30 degrees (unable to extend finger fully, painful extension begins at 31 degrees or more of flexion)

(Indicate fingers affected (check all that apply)):

Right:  Index finger  Long finger

Left:  Index finger  Long finger

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

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

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

YES  NO

If unable, provide reason: \_\_\_\_\_

If veteran is unable to perform, skip to Section V.)

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

4B. IS THERE ADDITIONAL LIMITATION OF MOTION FOR ANY FINGERS POST-TEST?

YES  NO

If "Yes," indicate digit(s) affected (check all that apply):

Right:  Thumb  Index finger  Long finger  Ring finger  Little finger

Left:  Thumb  Index finger  Long finger  Ring finger  Little finger

**SECTION IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING (Continued)**

4C. ABILITY TO OPPOSE THUMB: Is there a gap between the thumb pad and the fingers post-test?

YES  NO

If "Yes," indicate distance of gap and side affected)

Less than 1 inch (2.5cm.)  Right  Left  Both  
 1 to 2 inches (2.5 to 5.1 cm.)  Right  Left  Both  
 More than 2 inches (5.1 cm.)  Right  Left  Both

4D. FINGER FLEXION: Is there a gap between any fingertips and the proximal transverse crease of the palm in attempting to touch the palm with the fingertips post-test?

YES  NO

If "Yes," indicate the gap:

Gap less than 1 inch (2.5 cm) (Indicate fingers affected (check all that apply)):  
 Right:  Index finger  Long finger  Ring finger  Little finger  
 Left:  Index finger  Long finger  Ring finger  Little finger  
 Gap 1 inch (2.5 cm) or more (Indicate fingers affected (check all that apply)):  
 Right:  Index finger  Long finger  Ring finger  Little finger  
 Left:  Index finger  Long finger  Ring finger  Little finger

4E. FINGER EXTENSION: Is there limitation of extension for the index finger or long finger post-test?

YES  NO

If "Yes," indicate limitation of extension:

Extension limited by no more than 30 degrees (unable to extend finger fully, extension limited to between 0 and 30 degrees of flexion)  
 Indicate fingers affected (check all that apply):  
 Right:  Index finger  Long finger  
 Left:  Index finger  Long finger  
 Extension limited by more than 30 degrees (unable to extend finger fully, extension limited to 31 degrees or more of flexion)  
 Indicate fingers affected (check all that apply):  
 Right:  Index finger  Long finger  
 Left:  Index finger  Long finger

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

**NOTE:** The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

5A. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF ANY OF THE FINGERS OR THUMBS?

YES  NO

5B. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF ANY OF THE FINGERS OR THUMBS FOLLOWING REPETITIVE-USE TESTING?

YES  NO

5C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT OR ADDITIONAL LIMITATION OF ROM OF ANY OF THE FINGERS OR THUMBS AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW.

CHECK ALL THAT APPLY; INDICATE DIGIT AND SIDE AFFECTED:

- No functional loss for right hand, thumb or fingers
- No functional loss for left hand, thumb or fingers
- Less movement than normal  
 Right:  All  Thumb  Index finger  Long finger  Ring finger  Little finger  
 Left:  All  Thumb  Index finger  Long finger  Ring finger  Little finger
- More movement than normal  
 Right:  All  Thumb  Index finger  Long finger  Ring finger  Little finger  
 Left:  All  Thumb  Index finger  Long finger  Ring finger  Little finger
- Weakened movement  
 Right:  All  Thumb  Index finger  Long finger  Ring finger  Little finger  
 Left:  All  Thumb  Index finger  Long finger  Ring finger  Little finger
- Excess fatigability  
 Right:  All  Thumb  Index finger  Long finger  Ring finger  Little finger  
 Left:  All  Thumb  Index finger  Long finger  Ring finger  Little finger
- Incoordination, impaired ability to execute skilled movements smoothly  
 Right:  All  Thumb  Index finger  Long finger  Ring finger  Little finger  
 Left:  All  Thumb  Index finger  Long finger  Ring finger  Little finger
- Pain on movement  
 Right:  All  Thumb  Index finger  Long finger  Ring finger  Little finger  
 Left:  All  Thumb  Index finger  Long finger  Ring finger  Little finger
- Swelling  
 Right:  All  Thumb  Index finger  Long finger  Ring finger  Little finger  
 Left:  All  Thumb  Index finger  Long finger  Ring finger  Little finger



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

9A. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

YES  NO

(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches?):)

YES  NO

(If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

9B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

YES  NO (If "Yes," describe) (brief summary):

**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

10B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

**SECTION XI - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES**

11. DUE TO THE VETERAN'S HAND, FINGER OR THUMB CONDITIONS, 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.*)

YES, functioning is so diminished that amputation with prosthesis would equally serve the veteran.

NO

(If "Yes," indicate extremities for which this applies):

Right upper  Left upper

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

**SECTION XII - 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.

12A. HAVE IMAGING STUDIES OF THE HANDS BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO

(If "Yes," are there abnormal findings?)

YES  NO

(If "Yes," indicate findings):

Degenerative or traumatic arthritis

Hand:  Right  Left  Both

(Is degenerative or traumatic arthritis documented in multiple joints of the same hand, including thumb and fingers?)

YES  NO

(If "Yes," indicate hand):  Right  Left  Both

Other, describe: \_\_\_\_\_

Hand:  Right  Left  Both

12B. 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 XIII - FUNCTIONAL IMPACT**

13. DOES THE VETERAN'S HAND, THUMB OR FINGER CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

YES  NO (If "Yes," describe the impact of each of the veteran's hand, thumb and/or finger conditions, providing one or more examples):

**SECTION XIV - REMARKS**

14. REMARKS (If any)

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

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

15A. PHYSICIAN'S SIGNATURE		15B. PHYSICIAN'S PRINTED NAME	15C. DATE SIGNED
15D. PHYSICIAN'S PHONE AND FAX NUMBER	15E. PHYSICIAN'S MEDICAL LICENSE NUMBER	15F. 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.