OMB Approved No. 2900-0805
Respondent Burden: 30 minutes
Expiration Date: XX/XX/XXXX

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 - The veteran or service member 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 claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

MEDICAL RECORD REVIEW

WAS THE VETERAN'S VA CLAIMS FILE REVIEWED?

☐ YES ☐ NO

IF YES, LIST ANY RECORDS THAT WERE REVIEWED BUT WERE NOT INCLUDED IN THE VETERAN'S VA CLAIMS FILE:

IF NO, CHECK ALL RECORDS REVIEWED:

☐ Military service treatment records
☐ Military service personnel records
☐ Military enlistment examination
☐ Military separation examination
☐ Military post-deployment questionnaire
☐ Department of Defense Form 214 Separation Documents
☐ Veterans Health Administration medical records *(VA treatment records)*
☐ Civilian medical records
☐ Interviews with collateral witnesses *(family and others who have known the veteran before and after military service)*
☐ Other: _____
☐ No records were reviewed

SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS DBQ:

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) *(Check all that apply)*:

☐ The Veteran does not have a current diagnosis associated with any claimed condition listed above. *(Explain your findings and reasons in comments section.)*

☐	Wrist Sprain, Chronic	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Tendinitis, wrist	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Ganglion cyst	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Carpal metacarpal *(CMC)* arthritis	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Osteoarthritis arthritis, wrist	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	deQuervain's syndrome	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Triangular fibrocartilaginous complex *(TFCC)* injury	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Carpal instability *(intercalated segment/midcarpal/ scapholunate dissociation)*	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Avascular necrosis of carpal bones	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Wrist arthroplasty *(total/ulnar head replacement)*	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____
☐	Ankylosis of wrist	Side affected:	☐ Right	☐ Left	☐ Both	ICD Code: _____	Date of diagnosis: _____

☐ Other *(specify)*

Other diagnosis #1: _____

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: _____

Other diagnosis #2: _____

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SECTION I - DIAGNOSIS *(Continued)*

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: _____

Other diagnosis #3: _____

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: _____

1C. COMMENTS *(if any):*

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION *(internal VA only)*?

☐ YES ☐ NO ☐ N/A

SECTION II - MEDICAL HISTORY

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

2B. DOMINANT HAND:

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

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

☐ YES ☐ NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF THE IMPACT OF FLARE-UPS IN HIS OR HER OWN WORDS:

2D. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE JOINT OR EXTREMITY BEING EVALUATED ON THIS DBQ *(regardless of repetitive use)*?

☐ YES ☐ NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT IN HIS OR HER OWN WORDS:

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

Measure ROM with a goniometer. During the examination be cognizant of painful motion, which could be evidenced by visible behavior such as facial expression, wincing, etc..., on pressure or manipulation. Document painful movement in Section 5.

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 question 4A.

3A. INITIAL ROM MEASUREMENTS

Wrist	Joint Movement	ROM Measurement	If ROM testing is not indicated for the veteran's condition or not able to be performed, please explain why, and then proceed to Section 5:
RIGHT WRIST All Normal	Palmar Flexion (normal endpoint = 80 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
	Dorsiflexion (normal endpoint = 70 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
	Ulnar Deviation (normal endpoint = 45 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
	Radial Deviation (normal endpoint = 20 degrees)	_____ ☐ Not indicated ☐ Not able to perform	

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

3A. INITIAL ROM MEASUREMENTS *(Continued)*

Wrist	Joint Movement	ROM Measurement	If ROM testing is not indicated for the veteran's condition or not able to be performed, please explain why, and then proceed to Section 5:
LEFT WRIST All Normal	Palmar Flexion (normal endpoint = 80 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
	Dorsiflexion (normal endpoint = 70 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
	Ulnar Deviation (normal endpoint = 45 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
	Radial Deviation (normal endpoint = 20 degrees)	_____ ☐ Not indicated ☐ Not able to perform	

3B. DO ANY ABNORMAL ROMs NOTED ABOVE CONTRIBUTE TO FUNCTIONAL LOSS?

☐ YES *(you will be asked to further describe these limitations in Section 6 below)*

☐ NO, EXPLAIN WHY THE ABNORMAL ROMs DO NOT CONTRIBUTE:

3C. 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

4A. POST-TEST ROM MEASUREMENTS

Wrist	Is the veteran able to perform repetitive-use testing?	Is there additional limitation in ROM after repetitive-use testing?	Joint Movement	Post-test ROM Measurement
RIGHT WRIST	☐ Yes ☐ No If yes, perform repetitive-use testing If no, provide reason below, then proceed to Section 5	☐ Yes ☐ No, there is no change in ROM after repetitive testing If yes, report ROM after a minimum of 3 repetitions. If no, documentation of ROM after repetitive-use testing is not required.	Palmar Flexion	_____
			Dorsiflexion	_____
			Ulnar Deviation	_____
			Radial Deviation	_____
LEFT WRIST	☐ Yes ☐ No If yes, perform repetitive-use testing If no, provide reason below, then proceed to Section 5	☐ Yes ☐ No, there is no change in ROM after repetitive testing If yes, report ROM after a minimum of 3 repetitions. If no, documentation of ROM after repetitive-use testing is not required.	Palmar Flexion	_____
			Dorsiflexion	_____
			Ulnar Deviation	_____
			Radial Deviation	_____

4B. DO ANY POST-TEST ADDITIONAL LIMITATIONS OF ROMs NOTED ABOVE CONTRIBUTE TO FUNCTIONAL LOSS?

☐ YES *(you will be asked to further describe these limitations in Section 6 below)*

☐ NO, EXPLAIN WHY THE POST-TEST ADDITIONAL LIMITATIONS OF ROMs DO NOT CONTRIBUTE:

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SECTION V - PAIN

5A. ROM MOVEMENTS PAINFUL ON ACTIVE, PASSIVE AND/OR REPETITIVE USE TESTING

	Are any ROM movements painful on active, passive and/or repetitive use testing? *(If yes, identify whether active, passive, and/or repetitive use in question 5D)*	If yes *(there are painful movements)*, does the pain contribute to functional loss or additional limitation of ROM?	If no *(the pain does not contribute to functional loss or additional limitation of ROM)*, explain why the pain does not contribute:
RIGHT WRIST	☐ Yes ☐ No	☐ Yes *(you will be asked to further describe these limitations in Section 6 below)* ☐ No	
LEFT WRIST	☐ Yes ☐ No	☐ Yes *(you will be asked to further describe these limitations in Section 6 below)* ☐ No	

5B. PAIN WHEN USED IN WEIGHT-BEARING OR IN NON WEIGHT-BEARING

	Is there pain when the joint is used in weight-bearing or non weight? *(If yes, identify whether weight-bearing or non weight-bearing in question 5D)*	If yes *(there is pain when used in weight-bearing or non weight-bearing)*, does the pain contribute to functional loss or additional limitation of ROM?	If no *(the pain does not contribute to functional loss or additional limitation of ROM)*, explain why the pain does not contribute:
RIGHT WRIST	☐ Yes ☐ No	☐ Yes *(you will be asked to further describe these limitations in Section 6 below)* ☐ No	
LEFT WRIST	☐ Yes ☐ No	☐ Yes *(you will be asked to further describe these limitations in Section 6 below)* ☐ No	

5C. LOCALIZED TENDERNESS OR PAIN ON PALPATION

	Does the Veteran have localized tenderness or pain to palpation of joints or soft tissue?	If yes, describe including location, severity and relationship to condition(s) listed in the Diagnosis section:
RIGHT WRIST	☐ Yes ☐ No	
LEFT WRIST	☐ Yes ☐ No	

5D. COMMENTS, IF ANY:

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION OF ROM

NOTE: The VA defines functional loss as the inability, due to damage or infection in parts of the system, to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance. As regards the joints, factors of disability reside in reductions of their normal excursion of movements in different planes.
Using information from the history and physical exam, select the factors below that contribute to functional loss or impairment (regardless of repetitive use) or to additional limitation of ROM after repetitive use for the joint or extremity being evaluated on this DBQ:

6A. CONTRIBUTING FACTORS OF DISABILITY *(check all that apply and indicate side affected)*:

☐ No functional loss for left upper extremity attributable to claimed condition
☐ No functional loss for right upper extremity attributable to claimed condition
☐ Less movement than normal *(due to ankylosis, limitation or blocking, adhesions, tendon-tie-ups, contracted scars, etc.)* ☐ Right ☐ Left ☐ Both
☐ More movement than normal *(from flail joints, resections, nonunion of fractures, relaxation of ligaments, etc.)* ☐ Right ☐ Left ☐ Both
☐ Weakened movement *(due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.)* ☐ 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
☐ Instability of station ☐ Right ☐ Left ☐ Both
☐ Disturbance of locomotion ☐ Right ☐ Left ☐ Both
☐ Interference with sitting ☐ Right ☐ Left ☐ Both
☐ Interference with standing ☐ Right ☐ Left ☐ Both
☐ Other, describe:

NOTE: If any of the above factors is/are associated with limitation of motion, the examiner must give an opinion on whether pain, weakness, fatigability, or incoordination could significantly limit functional ability during flare-ups or when the joint is ***used repeatedly over a period of time*** and that opinion, if feasible, should be expressed in terms of the degree of additional ROM loss due to pain on use or during flare-ups. The following section will assist you in providing this required opinion.

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SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION OF ROM *(Continued)*

6B. ARE ANY OF THE ABOVE FACTORS ASSOCIATED WITH LIMITATION OF MOTION?

☐ YES *(If yes, complete questions 6C and 6D)*

☐ NO *(If no, proceed to question 6D)*

6C. CONTRIBUTING FACTORS OF DISABILITY ASSOCIATED WITH LIMITATION OF MOTION

Wrist	Can pain, weakness, fatigability, or incoordination significantly limit functional ability during flare-ups or when the joint is ***used repeatedly over a period of time?***	If yes, please estimate ROM due to pain and/or functional loss during flare-ups or when the joint is used repeatedly over a period of time:		If there is a functional loss due to pain, during flare-ups and/or when the joint is used repeatedly over a period of time but the limitation of ROM cannot be estimated, please describe the functional loss:
RIGHT WRIST	☐ Yes ☐ No	Palmar Flexion	_____ ☐ Est. ROM is not feasible	
		Dorsiflexion	_____ ☐ Est. ROM is not feasible	
		Ulnar Deviation	_____ ☐ Est. ROM is not feasible	
		Radial Deviation	_____ ☐ Est. ROM is not feasible	
LEFT WRIST	☐ Yes ☐ No	Palmar Flexion	_____ ☐ Est. ROM is not feasible	
		Dorsiflexion	_____ ☐ Est. ROM is not feasible	
		Ulnar Deviation	_____ ☐ Est. ROM is not feasible	
		Radial Deviation	_____ ☐ Est. ROM is not feasible	

6D. CONTRIBUTING FACTORS OF DISABILITY NOT ASSOCIATED WITH LIMITATION OF MOTION

IS THERE ANY FUNCTIONAL LOSS *(not associated with limitation of motion)* DURING FLARE-UPS OR WHEN THE JOINT IS USED REPEATEDLY OVER A PERIOD OF TIME OR OTHERWISE?

RIGHT WRIST: ☐ Yes ☐ No If yes, describe:

LEFT WRIST: ☐ Yes ☐ No If yes, describe:

SECTION VII - MUSCLE STRENGTH TESTING

7A. MUSCLE STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Wrist	Flexion /Extension	Rate Strength	Is there a reduction in muscle strength?	If yes, is the reduction entirely due to the claimed condition in the Diagnosis section?	If no (the reduction is not entirely due to the claimed condition), provide rationale:
RIGHT WRIST	Flexion	/5	☐ Yes ☐ No	☐ Yes ☐ No	
All Normal	Extension	/5			
LEFT WRIST	Flexion	/5	☐ Yes ☐ No	☐ Yes ☐ No	
All Normal	Extension	/5			

7B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

☐ YES ☐ NO

IF YES, IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO IF NO, PROVIDE RATIONALE:

IF YES, CONTINUE ON PAGE 6, ITEM 7B *(Continued)*.

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SECTION VII - MUSCLE STRENGTH TESTING *(Continued)*

7B. DOES THE VETERAN HAVE MUSCLE ATROPHY? *(Continued)*
FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSES LISTED IN SECTION 1, INDICATE SIDE AND SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK.

LOCATION OF MUSCLE ATROPHY:

☐ RIGHT UPPER EXTREMITY *(specify location of measurement such as "10cm above or below elbow")*:

_____

CIRCUMFERENCE OF MORE NORMAL SIDE: _____ cm CIRCUMFERENCE OF ATROPHIED SIDE: _____ cm

☐ LEFT UPPER EXTREMITY *(specify location of measurement such as "10cm above or below elbow")*:

_____

CIRCUMFERENCE OF MORE NORMAL SIDE: _____ cm CIRCUMFERENCE OF ATROPHIED SIDE: _____ cm

7C. COMMENTS, IF ANY:

SECTION VIII - ANKYLOSIS

NOTE: Ankylosis is the immobilization and consolidation of a joint due to disease, injury or surgical procedure.

COMPLETE THIS SECTION IF THE VETERAN HAS ANKYLOSIS OF THE WRIST.

8A. INDICATE SEVERITY OF ANKYLOSIS AND SIDE AFFECTED *(check all that apply)*:

RIGHT SIDE:

☐ Unfavorable, with ulnar deviation
If checked, provide degrees of ulnar deviation: _____

☐ Unfavorable, with radial deviation
If checked, provide degrees of radial deviation: _____

☐ Unfavorable, in any degree of palmar flexion
If checked, provide degrees of palmar flexion: _____

☐ Any other position except favorable
If checked, describe: _____

☐ Favorable in 20º to 30º dorsiflexion

☐ No ankylosis

LEFT SIDE:

☐ Unfavorable, with ulnar deviation
If checked, provide degrees of ulnar deviation: _____

☐ Unfavorable, with radial deviation
If checked, provide degrees of radial deviation: _____

☐ Unfavorable, in any degree of palmar flexion
If checked, provide degrees of palmar flexion: _____

☐ Any other position except favorable
If checked, describe: _____

☐ Favorable in 20º to 30º dorsiflexion

☐ No ankylosis

8B. COMMENTS, IF ANY:

SECTION IX - SURGICAL PROCEDURES

9. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED *(check all that apply)*:

RIGHT SIDE:

☐ TOTAL WRIST JOINT REPLACEMENT
DATE OF SURGERY: _____
RESIDUALS:
- ☐ None
- ☐ Intermediate degrees of residual weakness, pain or limitation of motion
- ☐ Chronic residuals consisting of severe painful motion or weakness
- ☐ Other, describe:

☐ ARTHROSCOPIC OR OTHER WRIST SURGERY
TYPE OF SURGERY: _____
DATE OF SURGERY: _____

☐ RESIDUALS OF ARTHROSCOPIC OR OTHER WRIST SURGERY
DESCRIBE RESIDUALS:

LEFT SIDE:

☐ TOTAL WRIST JOINT REPLACEMENT
DATE OF SURGERY: _____
RESIDUALS:
- ☐ None
- ☐ Intermediate degrees of residual weakness, pain or limitation of motion
- ☐ Chronic residuals consisting of severe painful motion or weakness
- ☐ Other, describe:

☐ ARTHROSCOPIC OR OTHER WRIST SURGERY
TYPE OF SURGERY: _____
DATE OF SURGERY: _____

☐ RESIDUALS OF ARTHROSCOPIC OR OTHER WRIST SURGERY
DESCRIBE RESIDUALS:

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

10A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS, OR ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO IF YES, COMPLETE QUESTIONS 10B-10D.

10B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO IF YES, DESCRIBE *(brief summary)*:

10C. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM *(6 square inches);* OR ARE LOCATED ON THE HEAD, FACE OR NECK?

☐ YES ☐ NO IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

Location: _____ Measurements: length _____ cm X width _____ cm.

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

10D. COMMENTS, IF ANY:

SECTION XI - ASSISTIVE DEVICES

11A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES?

☐ YES ☐ NO IF YES, IDENTIFY ASSISTIVE DEVICES USED *(check all that apply and indicate frequency):*

☐ Brace Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

☐ Other: _____ Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

11B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION XII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

12A. DUE TO THE VETERAN'S WRIST CONDITIONS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAIN 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 PROTHESIS 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)*:

NOTE: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prothesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

SECTION XIII - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, even if in the past, no further imaging studies are required by VA, even if arthritis has worsened.

13A. HAVE IMAGING STUDIES OF THE WRIST BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

☐ YES ☐ NO IF YES, INDICATE WRIST: ☐ RIGHT ☐ LEFT ☐ BOTH

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SECTION XIII - DIAGNOSTIC TESTING *(Continued)*

13B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS OR RESULTS?

☐ YES ☐ NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

13C. IS THERE OBJECTIVE EVIDENCE OF CREPITUS?

☐ YES ☐ NO IF YES, INDICATE WRIST: ☐ RIGHT ☐ LEFT ☐ BOTH

13D. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

SECTION XIV - FUNCTIONAL IMPACT

NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

14. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK *(such as standing, walking, lifting, sitting, etc.)*?

☐ YES ☐ NO IF YES, DESCRIBE THE FUNCTIONAL IMPACT OF EACH CONDITION, PROVIDING ONE OR MORE EXAMPLES:

SECTION XV - REMARKS

15. REMARKS, IF ANY:

SECTION XVI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

16A. PHYSICIAN'S SIGNATURE *(Sign in ink)*	16B. PHYSICIAN'S PRINTED NAME	16C. DATE SIGNED

16D. PHYSICIAN'S PHONE AND FAX NUMBER	16E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	16F. 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.