



**AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE)
 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

- -

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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS)?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO AMYOTROPHIC LATERAL SCLEROSIS (ALS):

Diagnosis # 1 -	ICD code -	Date of diagnosis -
Diagnosis # 2 -	ICD code -	Date of diagnosis -
Diagnosis # 3 -	ICD code -	Date of diagnosis -

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO AMYOTROPHIC LATERAL SCLEROSIS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

2B. DOMINANT HAND

RIGHT LEFT AMBIDEXTROUS

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS

3A. DOES THE VETERAN HAVE ANY MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES ATTRIBUTABLE TO ALS?

YES NO

(If "Yes," report under strength testing in Section IV, Neurologic Exam)

3B. DOES THE VETERAN HAVE ANY PHARYNX AND/OR LARYNX AND/OR SWALLOWING CONDITIONS ATTRIBUTABLE TO ALS?

YES NO

(If "Yes," check all that apply)

- CONSTANT INABILITY TO COMMUNICATE BY SPEECH
- SPEECH NOT INTELLIGIBLE OR INDIVIDUAL IS APHONIC
- PARALYSIS OF SOFT PALATE WITH SWALLOWING DIFFICULTY *(nasal regurgitation)* AND SPEECH IMPAIRMENT
- HOARSENESS
- MILD SWALLOWING DIFFICULTIES
- MODERATE SWALLOWING DIFFICULTIES
- SEVERE SWALLOWING DIFFICULTIES, PERMITTING PASSAGE OF LIQUIDS ONLY
- REQUIRES FEEDING TUBE DUE TO SWALLOWING DIFFICULTIES
- OTHER *(describe)*: _____

3C. DOES THE VETERAN HAVE ANY RESPIRATORY CONDITIONS ATTRIBUTABLE TO ALS?

YES NO

(If "Yes," provide PFT results in Section XIII, Diagnostic Testing)

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS (Continued)

3D. DOES THE VETERAN HAVE SIGNS AND/OR SYMPTOMS OF SLEEP APNEA OR SLEEP APNEA-LIKE CONDITION ATTRIBUTABLE TO ALS?

NOTE: If signs and/or symptoms of sleep apnea or sleep apnea-like condition are due to ALS, these symptoms are due to weakness in the palatal, pharyngeal, laryngeal, and/or respiratory musculature. A sleep study is not indicated to report symptoms of sleep apnea or sleep apnea-like conditions that are attributable to ALS.

YES NO

(If "Yes," check all that apply)

- PERSISTENT DAYTIME HYPERSOMNOLENCE
- REQUIRES USE OF BREATHING ASSISTANCE DEVICE SUCH AS CONTINUOUS AIRWAY PRESSURE (CPAP) MACHINE
- CHRONIC RESPIRATORY FAILURE WITH CARBON DIOXIDE RETENTION OR COR PULMONALE
- REQUIRES TRACHEOSTOMY

3E. DOES THE VETERAN HAVE ANY BOWEL IMPAIRMENT ATTRIBUTABLE TO ALS?

YES NO

(If "Yes," check all that apply)

- SLIGHT IMPAIRMENT OF SPHINCTER CONTROL, WITHOUT LEAKAGE
- CONSTANT SLIGHT IMPAIRMENT OF SPHINCTER CONTROL, OR OCCASIONAL MODERATE LEAKAGE
- OCCASIONAL INVOLUNTARY BOWEL MOVEMENTS, NECESSITATING WEARING OF A PAD
- EXTENSIVE LEAKAGE AND FAIRLY FREQUENT INVOLUNTARY BOWEL MOVEMENTS
- TOTAL LOSS OF BOWEL SPHINCTER CONTROL
- CHRONIC CONSTIPATION
- OTHER BOWEL IMPAIRMENT *(describe):* _____

3F. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING URINE LEAKAGE ATTRIBUTABLE TO ALS?

YES NO

(If "Yes," check all that apply)

- DOES NOT REQUIRE/DOES NOT USE ABSORBENT MATERIAL
- REQUIRES ABSORBENT MATERIAL THAT IS CHANGED LESS THAN 2 TIMES PER DAY
- REQUIRES ABSORBENT MATERIAL THAT IS CHANGED 2 TO 4 TIMES PER DAY
- REQUIRES ABSORBENT MATERIAL THAT IS CHANGED MORE THAN 4 TIMES PER DAY

3G. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING SIGNS AND/OR SYMPTOMS OF URINARY FREQUENCY ATTRIBUTABLE TO ALS?

YES NO

(If "Yes," check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> DAYTIME VOIDING INTERVAL GREATER THAN 3 HOURS | <input type="checkbox"/> NIGHTTIME AWAKENING TO VOID LESS THAN 2 TIMES |
| <input type="checkbox"/> DAYTIME VOIDING INTERVAL BETWEEN 2 AND 3 HOURS | <input type="checkbox"/> NIGHTTIME AWAKENING TO VOID 2 TIMES |
| <input type="checkbox"/> DAYTIME VOIDING INTERVAL BETWEEN 1 AND 2 HOURS | <input type="checkbox"/> NIGHTTIME AWAKENING TO VOID 3 TO 4 TIMES |
| <input type="checkbox"/> DAYTIME VOIDING INTERVAL LESS THAN 1 HOUR | <input type="checkbox"/> NIGHTTIME AWAKENING TO VOID 5 OR MORE TIMES |

3H. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING FINDINGS, SIGNS AND/OR SYMPTOMS OF OBSTRUCTED VOIDING ATTRIBUTABLE TO ALS?

YES NO

(If "Yes," check all signs and symptoms that apply)

- HESITANCY
(If checked, is hesitancy marked?)
 YES NO
- SLOW OR WEAK STREAM
(If checked, is stream markedly slow or weak?)
 YES NO
- DECREASED FORCE OF STREAM
(If checked, is force of stream markedly decreased?)
 YES NO
- STRICTURE DISEASE REQUIRING DILATATION 1 TO 2 TIMES PER YEAR
- STRICTURE DISEASE REQUIRING PERIODIC DILATATION EVERY 2 TO 3 MONTHS
- RECURRENT URINARY TRACT INFECTIONS SECONDARY TO OBSTRUCTION
- UROFLOWMETRY PEAK FLOW RATE LESS THAN 10cc/sec
- POST VOID RESIDUALS GREATER THAN 150 cc
- URINARY RETENTION REQUIRING INTERMITTENT OR CONTINUOUS CATHETERIZATION

3I. DOES THE VETERAN HAVE VOIDING DYSFUNCTION REQUIRING THE USE OF AN APPLIANCE ATTRIBUTABLE TO ALS?

YES NO *(If "Yes," describe appliance):*

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO ALS (Continued)

3J. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT INFECTIONS ATTRIBUTABLE TO ALS?

YES NO

(If "Yes," check all treatments that apply)

NO TREATMENT

LONG-TERM DRUG THERAPY

(If checked, list medications used for urinary tract infection and indicate dates for courses of treatment over the past 12 months)

HOSPITALIZATION

(If checked, indicate frequency of hospitalization)

1 or 2 per year

More than 2 per year

DRAINAGE

(If checked, indicate dates when drainage performed over past 12 months): _____

OTHER MANAGEMENT/TREATMENT NOT LISTED ABOVE *(Description of management/treatment including dates of treatment):* _____

3K. DOES THE VETERAN *(if male)* HAVE ERECTILE DYSFUNCTION?

YES NO

(If "Yes," is the erectile dysfunction as likely as not (at least a 50% probability) attributable to ALS?)

YES NO

(If "No," provide the etiology of the erectile dysfunction): _____

(If "Yes," is the veteran able to achieve an erection (without medication) sufficient for penetration and ejaculation?)

YES NO

(If "No," is the veteran able to achieve an erection (with medication) sufficient for penetration and ejaculation?)

YES NO

SECTION IV - NEUROLOGIC EXAM

4A. SPEECH

NORMAL ABNORMAL

(If speech is abnormal, describe): _____

4B. GAIT

NORMAL ABNORMAL *(describe):* _____

(If gait is abnormal and the veteran has more than one medical condition contributing to the abnormal gait, identify the condition(s) and describe each condition's contribution to the abnormal gait): _____

4C. STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement

2/5 No movement against gravity

4/5 Less than normal strength

1/5 Visible muscle movement, but no joint movement

3/5 No movement against resistance

5/5 Normal strength

ALL NORMAL

Elbow Flexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Elbow Extension:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist Flexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist Extension:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Grip:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Pinch: <i>(thumb to index finger)</i>	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Knee Flexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Knee Extension:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle Plantar Flexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle Dorsiflexion:	RIGHT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	LEFT:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5

SECTION IV - NEUROLOGIC EXAM (Continued)

4D. DEEP TENDON REFLEXES (DTRs) - RATE REFLEXES ACCORDING TO THE FOLLOWING SCALE:

0 Absent 1+ Decreased 2+ Normal 3+ Increased without clonus 4+ Increased with clonus

ALL NORMAL

Biceps:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Triceps:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Brachioradialis:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Knee:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Ankle:	RIGHT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	LEFT:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

4E. PLANTAR (Babinski) REFLEX

RIGHT: Plantar flexion (normal, or negative Babinski)
 Dorsiflexion (abnormal, or positive Babinski)

LEFT: Plantar flexion (normal, or negative Babinski)
 Dorsiflexion (abnormal, or positive Babinski)

4F. DOES THE VETERAN HAVE MUSCLE ATROPHY ATTRIBUTABLE TO ALS?

YES NO (If muscle atrophy is present, indicate location): _____
 (When possible, provide difference measured in cm between normal and atrophied side, measured at maximum muscle bulk: _____ cm.)

4G. SUMMARY OF MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES ATTRIBUTABLE TO ALS (check all that apply):

Right upper extremity muscle weakness:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> With atrophy	<input type="checkbox"/> Complete (no remaining function)
Left upper extremity muscle weakness:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> With atrophy	<input type="checkbox"/> Complete (no remaining function)
Right lower extremity muscle weakness:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> With atrophy	<input type="checkbox"/> Complete (no remaining function)
Left lower extremity muscle weakness:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> With atrophy	<input type="checkbox"/> Complete (no remaining function)

NOTE: If the Veteran has more than one medical condition contributing to the muscle weakness, identify the condition(s) and describe each condition's contribution to the muscle weakness:

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

5A. 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 or equal to 39 square cm (6 square inches)?
 Yes No (If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ALS?

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

SECTION VI - MENTAL HEALTH MANIFESTATIONS DUE TO ALS OR ITS TREATMENT

6A. DOES THE VETERAN HAVE DEPRESSION, COGNITIVE IMPAIRMENT OR DEMENTIA, OR ANY OTHER MENTAL DISORDER ATTRIBUTABLE TO ALS AND/OR ITS TREATMENT?

YES NO (If "Yes," complete Item 6B)

6B. DOES THE VETERAN'S MENTAL DISORDER, AS IDENTIFIED IN ITEM 6A, RESULT IN GROSS IMPAIRMENT IN THOUGHT PROCESSES OR COMMUNICATION?

YES NO (If "Yes," ALSO complete VA Form 21-0960P-2, Mental Disorders (Other than PTSD) Disability Benefits Questionnaire)
 (Schedule with appropriate provider)
 (If "Yes," briefly describe the veteran's mental disorder):

SECTION VII - HOUSEBOUND

7A. IS THE VETERAN SUBSTANTIALLY CONFINED TO HIS OR HER DWELLING AND THE IMMEDIATE PREMISES (or if institutionalized, to the ward or clinical areas)?

YES NO (If "Yes," complete Item 7B)

(If "Yes," describe how often per day or week and under what circumstances the veteran is able to leave the home or immediate premises):

7B. DOES THE VETERAN HAVE MORE THAN ONE CONDITION CONTRIBUTING TO HIS OR HER BEING HOUSEBOUND?

YES NO (If "Yes," list conditions and describe how each condition contributes to causing the veteran to be housebound):

Condition # 1: _____	Describe how condition #1 contributes to causing the veteran to be housebound: <input style="width: 100%; height: 20px;" type="text"/>
Condition # 2: _____	Describe how condition #2 contributes to causing the veteran to be housebound: <input style="width: 100%; height: 20px;" type="text"/>
Condition # 3: _____	Describe how condition #3 contributes to causing the veteran to be housebound: <input style="width: 100%; height: 20px;" type="text"/>

7C. IF THE VETERAN HAS ADDITIONAL CONDITIONS CONTRIBUTING TO CAUSING THE VETERAN TO BE HOUSEBOUND, LIST USING FORMAT SHOWN IN ITEM 7B?

SECTION VIII - AID AND ATTENDANCE

8A. IS THE VETERAN ABLE TO DRESS OR UNDESS HIM OR HERSELF WITHOUT ASSISTANCE?

YES NO

(If "No," is this limitation caused by the veteran's ALS?)

Yes No

8B. DOES THE VETERAN HAVE SUFFICIENT UPPER EXTREMITY COORDINATION AND STRENGTH TO BE ABLE TO FEED HIM OR HERSELF WITHOUT ASSISTANCE?

YES NO

(If "No," is this limitation caused by the veteran's ALS?)

Yes No

8C. IS THE VETERAN ABLE TO ATTEND TO THE WANTS OF NATURE (toileting) WITHOUT ASSISTANCE?

YES NO

(If "No," is this limitation caused by the veteran's ALS?)

Yes No

8D. IS THE VETERAN ABLE TO BATHE HIM OR HERSELF WITHOUT ASSISTANCE?

YES NO

(If "No," is this limitation caused by the veteran's ALS?)

Yes No

8E. IS THE VETERAN ABLE TO KEEP HIM OR HERSELF ORDINARILY CLEAN AND PRESENTABLE WITHOUT ASSISTANCE?

YES NO

(If "No," is this limitation caused by the veteran's ALS?)

Yes No

8F. DOES THE VETERAN NEED FREQUENT ASSISTANCE FOR ADJUSTMENT OF ANY SPECIAL PROSTHETIC OR ORTHOPEDIC APPLIANCE(S)?

YES NO (If "Yes," describe):

NOTE: For VA purposes, "bedridden" will be that condition which actually requires that the claimant remain in bed. The fact that claimant has voluntarily taken to bed or that a physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure will not suffice.

8G. IS THE VETERAN BEDRIDDEN?

YES NO

(If "Yes," is it due to the veteran's ALS?)

Yes No

8H. DOES THE VETERAN REQUIRE CARE AND/OR ASSISTANCE ON A REGULAR BASIS DUE TO HIS OR HER PHYSICAL AND/OR MENTAL DISABILITIES IN ORDER TO PROTECT HIM OR HERSELF FROM THE HAZARDS AND/OR DANGERS INCIDENT TO HIS OR HER DAILY ENVIRONMENT?

YES NO

(If "Yes," is it due to the veteran's ALS?)

Yes No

8I. LIST ANY CONDITION(S), IN ADDITION TO THE VETERAN'S ALS, THAT CAUSES ANY OF THE ABOVE LIMITATIONS:

SECTION IX - ASSISTIVE DEVICES

9A. DOES THE VETERAN USE ANY ASSISTIVE DEVICE(S) AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

YES NO

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

- | | | | | |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> WHEELCHAIR | Frequency of use: | <input type="checkbox"/> occasional | <input type="checkbox"/> regular | <input type="checkbox"/> constant |
| <input type="checkbox"/> BRACE(S) | Frequency of use: | <input type="checkbox"/> occasional | <input type="checkbox"/> regular | <input type="checkbox"/> constant |
| <input type="checkbox"/> CRUTCH(ES) | Frequency of use: | <input type="checkbox"/> occasional | <input type="checkbox"/> regular | <input type="checkbox"/> constant |
| <input type="checkbox"/> CANE(S) | Frequency of use: | <input type="checkbox"/> occasional | <input type="checkbox"/> regular | <input type="checkbox"/> constant |
| <input type="checkbox"/> WALKER | Frequency of use: | <input type="checkbox"/> occasional | <input type="checkbox"/> regular | <input type="checkbox"/> constant |
| <input type="checkbox"/> OTHER: _____ | Frequency of use: | <input type="checkbox"/> occasional | <input type="checkbox"/> regular | <input type="checkbox"/> constant |

9B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION X - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

10A. DUE TO ALS CONDITION, 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 PROTHESIS WOULD EQUALLY SERVE THE VETERAN
 NO

(If "Yes," complete Item 10B)

10B. INDICATE EXTREMITY(IES) (Check all extremities for which this applies)

RIGHT UPPER LEFT UPPER RIGHT LOWER LEFT LOWER

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

SECTION XI - FINANCIAL RESPONSIBILITY

11. IN YOUR JUDGMENT, IS THE VETERAN ABLE TO MANAGE HIS OR HER BENEFIT PAYMENTS IN HIS OR HER OWN BEST INTEREST, OR ABLE TO DIRECT SOMEONE ELSE TO DO SO?

YES NO

(If "No," provide rationale):

SECTION XII - DIAGNOSTIC TESTING

NOTE - If pulmonary function testing (PFT) is indicated due to respiratory disability, and results are in the medical record and reflect the veteran's current respiratory function, repeat testing is not required. DLCO and bronchodilator testing is not indicated for a restrictive respiratory disability such as that caused by muscle weakness due to ALS.

12A. HAVE PFTs BEEN PERFORMED?

YES NO

(If "Yes," provide most recent results, if available):

FEV-1: _____ % predicted Date of test: _____

FVC: _____ % predicted Date of test: _____

FEV-1/FVC: _____ % Date of test: _____

12B. IF PFTs HAVE BEEN PERFORMED, IS THE FLOW-VOLUME LOOP COMPATIBLE WITH UPPER AIRWAY OBSTRUCTION?

YES NO

12C. 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 ALS IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe the impact of the veteran's ALS, 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. NATIONAL PROVIDER IDENTIFIER (NPI) 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.benefits.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 voluntary. 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.