OMB Control No. 2900-0778
Respondent Burden: 45 Minutes
Expiration Date: 09/30/2019

Department of Veterans Affairs

MULTIPLE SCLEROSIS (MS) 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 THIS FORM.

NAME OF PATIENT/VETERAN *(First, Middle Initial, Last)*

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 HAVE MULTIPLE SCLEROSIS (MS)?

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. 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 the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date is determined through record review or reported history.

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO MS:

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 MS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

2B. DOMINANT HAND

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS DUE TO MS

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

☐ YES ☐ NO *(If "Yes," report under strength testing in neurologic exam section)*

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

☐ 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 MS?

☐ YES ☐ NO *(If "Yes," provide PFT results under "Diagnostic Testing" section and complete VA Form 21-0960L-1, Respiratory Conditions (other than Tuberculosis and Sleep Apnea) Disability Benefits Questionnaire)*

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

3D. DOES THE VETERAN HAVE SLEEP DISTURBANCES ATTRIBUTABLE TO MS?

☐ YES ☐ NO

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

- ☐ Insomnia
- ☐ Hypersomnolence and/or daytime “sleep attacks "
- ☐ Persistent daytime hypersomnolence
- ☐ Sleep apnea requiring the use of breathing assistance device such as continuous airway pressure *(CPAP)* machine
- ☐ Sleep apnea causing chronic respiratory failure with carbon dioxide retention or cor pulmonale
- ☐ Sleep apnea requiring tracheostomy

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

☐ YES ☐ NO

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

- ☐ Slight impairment of sphincter control, without leakage
- ☐ Constant slight leakage
- ☐ 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 MS?

☐ 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 URINARY FREQUENCY ATTRIBUTABLE TO MS?

☐ YES ☐ NO

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

- ☐ Daytime voiding interval between 2 and 3 hours
- ☐ Daytime voiding interval between 1 and 2 hours
- ☐ Daytime voiding interval less than 1 hour
- ☐ Nighttime awakening to void 2 times
- ☐ Nighttime awakening to void 3 to 4 times
- ☐ Nighttime awakening to void 5 or more times

3H. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING OBSTRUCTED VOIDING ATTRIBUTABLE TO MS?

☐ 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 10 cc/sec
- ☐ Post void residuals greater than 150 cc
- ☐ Urinary retention requiring intermittent or continuous catheterization

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

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

☐ YES ☐ NO

(If "Yes," describe):

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

☐ 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 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

3L. VISUAL DISTURBANCES

DOES THE VETERAN HAVE ANY VISUAL DISTURBANCES ATTRIBUTABLE TO MS?

☐ YES ☐ NO

(If "Yes," check all that apply, also complete VA Form 21-0960N-2, Eye Conditions Disability Benefits Questionnaire and schedule with appropriate examiner):

☐ Diplopia

☐ Blurring of vision

☐ Internuclear ophthalmoplegia

☐ Decreased visual acuity *(If checked, specify):* ☐ unilateral ☐ bilateral

☐ Visual scotoma *(If checked, specify):* ☐ unilateral ☐ bilateral

☐ Nystagmus

☐ Optic neuritis

☐ Other *(describe):* _____

SECTION IV - NEUROLOGIC EXAM

4A. GAIT

☐ NORMAL ☐ ABNORMAL *(describe):* _____

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

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SECTION IV - NEUROLOGIC EXAM *(Continued)*

4B. STRENGTH - 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

Shoulder 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
Shoulder 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 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
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
Grip	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
Pinch *(thumb to index finger)*	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
Hip 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
Hip 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
Knee 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
Ankle Plantar 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
Ankle Dorsiflexion	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

IF THERE ARE OTHER WEAKNESSES, PLEASE SPECIFY USING THE ABOVE FORMAT:

4C. 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

Biceps	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Triceps	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Brachioradialis	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Knee	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Ankle	RIGHT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	LEFT:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+

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SECTION IV - NEUROLOGIC EXAM *(Continued)*

4D. SENSATION TESTING RESULTS:

Shoulder area *(C5)*	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Inner/outer forearm *(C6/T1)*	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Hand/fingers *(C6-8)*	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Thorax:				
Anterior:	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Posterior:	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Trunk:				
Anterior:	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Posterior:	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Thigh/knee *(L3/4)*	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Lower leg/ankle *(L4/L5/S1)*	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent
Foot/toes *(L5)*	RIGHT:	☐ Normal	☐ Decreased	☐ Absent
	LEFT:	☐ Normal	☐ Decreased	☐ Absent

4E. DOES THE VETERAN HAVE MUSCLE ATROPHY ATTRIBUTABLE TO MS?

☐ 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.)

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

RIGHT UPPER EXTREMITY MUSCLE WEAKNESS:

☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE ☐ WITH ATROPHY ☐ COMPLETE *(no remaining function)*

LEFT UPPER EXTREMITY MUSCLE WEAKNESS:

☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE ☐ WITH ATROPHY ☐ COMPLETE *(no remaining function)*

RIGHT LOWER EXTREMITY MUSCLE WEAKNESS:

☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE ☐ WITH ATROPHY ☐ COMPLETE *(no remaining function)*

LEFT LOWER EXTREMITY MUSCLE WEAKNESS:

☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE ☐ WITH ATROPHY ☐ 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 THE DIAGNOSIS SECTION?

☐ 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 DISABILITY BENEFITS QUESTIONNAIRE.

IF NO, PROVIDE LOCATION AND MEASURMENTS 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 the Remarks section below. It is not necessary to also complete a Scars DBQ.

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SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS *(Continued)*

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

(If "Yes," describe in a brief summary):

SECTION VI - MENTAL HEALTH MANIFESTATIONS DUE TO MULTIPLE SCLEROSIS OR ITS TREATMENT

6A. DOES THE VETERAN HAVE SIGNS OR SYMPTOMS OF DEPRESSION, COGNITIVE IMPAIRMENT OR DEMENTIA, OR ANY OTHER MENTAL HEALTH CONDITIONS ATTRIBUTABLE TO MS AND/OR ITS TREATMENT?

☐ YES ☐ NO *(If "Yes," briefly describe):*

(If "Yes," also complete VA Form 21-0960P-2, Mental Disorders (other than PTSD and Eating Disorders) Disability Benefits Questionnaire and schedule with appropriate provider)

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

☐ YES ☐ NO

(If "No," also complete VA Form 21-0960P-2, Mental Disorders (other than PTSD and Eating Disorders) Disability Benefits Questionnaire and schedule with appropriate provider).

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

7B. IF YES, 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)*

PROVIDE CONDITIONS AND DESCRIBE HOW EACH CONDITION CONTRIBUTES TO THE VETERAN BEING HOUSEBOUND

CONDITION # 1 -	DESCRIPTION -
CONDITION # 2 -	DESCRIPTION -
CONDITION # 3 -	DESCRIPTION -

7C. IF THE VETERAN HAS ADDITIONAL CONDITIONS CONTRIBUTING TO CAUSING THE VETERAN TO BE HOUSEBOUND, LIST USING ABOVE FORMAT:

SECTION VIII - AID AND ATTENDANCE

8A. IS THE VETERAN ABLE TO DRESS OR UNDRESS WITHOUT ASSISTANCE?

☐ YES ☐ NO

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

☐ 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 MS?)

☐ YES ☐ NO

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SECTION VIII - AID AND ATTENDANCE ***(Continued)***

8C. IS THE VETERAN ABLE TO PREPARE MEALS WITHOUT ASSISTANCE?

☐ YES ☐ NO

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

☐ YES ☐ NO

8D. 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 MS?)

☐ YES ☐ NO

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

☐ YES ☐ NO

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

☐ YES ☐ NO

8F. 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 MS?)

☐ YES ☐ NO

8G. IS THE VETERAN ABLE TO TAKE PRESCRIPTION MEDICATIONS IN A TIMELY MANNER AND WITH ACCURATE DOSAGE WITHOUT ASSISTANCE?

☐ YES ☐ NO

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

☐ YES ☐ NO

8H. 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 the 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.

8I. IS THE VETERAN BEDRIDDEN?

☐ YES ☐ NO

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

☐ YES ☐ NO

8J. IS THE VETERAN LEGALLY BLIND?

☐ YES ☐ NO

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

☐ YES ☐ NO

Provide best corrected vision, if known: Left Eye: _____ Right Eye: _____

8K. 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 MS?)

☐ YES ☐ NO

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

SECTION IX - NEED FOR HIGHER LEVEL *(i.e., more skilled)* **A&A**

9. DOES THE VETERAN REQUIRE A HIGHER, MORE SKILLED LEVEL OF A&A?

☐ YES ☐ NO

NOTE: For VA purposes, this skilled, higher level care includes (but is not limited to) health-care services such as physical therapy, administration of injections, placement of indwelling catheters, changing of sterile dressings, and/or like functions which require professional health-care training or the regular supervision of a trained health-care professional to perform. In the absence of this higher level of care provided in the home, the veteran would require hospitalization, nursing home care, or other residential institutional care.

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SECTION X - ASSISTIVE DEVICES

10A. 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)

☐ WHEELCHAIR	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ BRACE(S)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ CRUTCH(ES)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ CANE(S)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ WALKER	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 ASSITIVE DEVICE USED FOR EACH CONDITION:

SECTION XI - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

11. DUE TO MULTIPLE SCLEROSIS, 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

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

SECTION XII - FINANCIAL RESPONSIBILITY

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

☐ YES ☐ NO *(If "No," provide reason):*

SECTION XIII - DIAGNOSTIC TESTING

NOTE: If the results of MRI, other imaging studies or other diagnostic tests are in the medical record and reflect the veteran's current condition, repeat testing is not required. 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 MS.

13A. HAVE IMAGING STUDIES BEEN PERFORMED?

☐ YES ☐ NO

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

13B. HAVE PFT's BEEN PERFORMED?

☐ YES ☐ NO

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

FEV1: _____ % predicted Date of test: _____

FEV1/FVC: _____ % Date of test: _____

FVC: _____ % predicted Date of test: _____

13C. IF PFT's HAVE BEEN PERFORMED, IS THE FLOW-VOLUME LOOP COMPATIBLE WITH UPPER AIRWAY OBSTRUCTION?

☐ YES ☐ NO

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION XIII - DIAGNOSTIC TESTING *(Continued)*

13D. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

(If "Yes," provide type of test or procedure, date and results, in a brief summary):

SECTION XIV - FUNCTIONAL IMPACT

14. DOES THE VETERAN'S MS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of the veteran's MS, 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	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.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, 58VA21/22/28, 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 45 minutes to review the instructions, find the information, and complete a 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.