



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 BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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.

Note - The Veteran 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 may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL questionnaires completed by providers. It is intended that this questionnaire will be completed by the Veteran's provider.

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Other: please describe

Are you a VA Healthcare provider? Yes No

Is the Veteran regularly seen as a patient in your clinic? Yes No

Was the Veteran examined in person? Yes No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH PARKINSON'S DISEASE OR PARKINSONISM?

1B. ICD CODES(S)

1C. DATE OF DIAGNOSIS

YES NO

IF YES, INDICATE WHICH CONDITION:

PARKINSON'S DISEASE PARKINSONISM

SECTION II - DOMINANT HAND

2. DOMINANT HAND

RIGHT LEFT AMBIDEXTROUS

SECTION III - MOTOR MANIFESTATIONS

3. MOTOR MANIFESTATIONS DUE TO PARKINSON'S / PARKINSONISM OR ITS TREATMENT (Check all that apply)

MOTOR MANIFESTATIONS	NONE	MILD	MODERATE	SEVERE
3A. STOOPED POSTURE				
3B. BALANCE IMPAIRMENT				
3C. BRADYKINESIA OR SLOWED MOTION (Difficulty initiating movement, "freezing," short shuffling steps)				
3D. LOSS OF AUTOMATIC MOVEMENTS (Such as blinking, leading to fixed gaze, typical Parkinson's facies)				
3E. SPEECH CHANGES (Monotone, slurring words, soft or rapid speech)				

3F. TREMOR (Characteristic hand shaking, "pill-rolling") YES NO

EXTREMITIES AFFECTED:

RIGHT UPPER

NOT AFFECTED MILD MODERATE SEVERE

LEFT UPPER

NOT AFFECTED MILD MODERATE SEVERE

RIGHT LOWER

NOT AFFECTED MILD MODERATE SEVERE

LEFT LOWER

NOT AFFECTED MILD MODERATE SEVERE

3G. MUSCLE RIGIDITY AND STIFFNESS YES NO

EXTREMITIES AFFECTED:

RIGHT UPPER

NOT AFFECTED MILD MODERATE SEVERE

LEFT UPPER

NOT AFFECTED MILD MODERATE SEVERE

RIGHT LOWER

NOT AFFECTED MILD MODERATE SEVERE

LEFT LOWER

NOT AFFECTED MILD MODERATE SEVERE

SECTION IV - MENTAL MANIFESTATIONS

4. MENTAL MANIFESTATIONS DUE TO PARKINSON'S / PARKINSONISM OR ITS TREATMENT (Check all that apply)

MENTAL MANIFESTATIONS	NONE	MILD	MODERATE	SEVERE
4A. DEPRESSION				
4B. COGNITIVE IMPAIRMENT OR DEMENTIA				

SECTION V - ADDITIONAL MANIFESTATIONS/COMPLICATIONS

5. ADDITIONAL MANIFESTATIONS/COMPLICATIONS DUE TO PARKINSON'S / PARKINSONISM OR ITS TREATMENT

5A. LOSS OF SENSE OF SMELL

NONE PARTIAL COMPLETE

SECTION V - ADDITIONAL MANIFESTATIONS/COMPLICATIONS

5. ADDITIONAL MANIFESTATIONS/COMPLICATIONS DUE TO PARKINSON'S / PARKINSONISM OR ITS TREATMENT

ADDITIONAL MANIFESTATIONS/COMPLICATIONS	NONE	MILD	MODERATE	SEVERE
5B. SLEEP DISTURBANCE (Insomnia or daytime "sleep attacks")				
5C. DIFFICULTY CHEWING/SWALLOWING				
5D. URINARY PROBLEMS (Incontinence or urinary retention) Indicate "None" or, if absorbent material required due to incontinence, specify pads/day <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> >4 USE OF AN APPLIANCE REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO				
5E. CONSTIPATION (due to slowing of GI tract or secondary to Parkinson's medications)				
5F. SEXUAL DYSFUNCTION				(Precludes intercourse, including erectile dysfunction)
5G. OTHER MANIFESTATIONS/COMPLICATIONS (Specify):				

SECTION VI - FINANCIAL RESPONSIBILITY

6. FINANCIAL RESPONSIBILITY - 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

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S PARKINSON'S / PARKINSONISM IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe impact and provide one or more examples)

SECTION VIII - REMARKS

8. ADDITIONAL REMARKS (If any)

SECTION IX - EXAMINER'S CERTIFICATION AND SIGNATURE

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

9A. Examiner's signature:

9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

9D. Date Signed:

9E. Examiner's phone/fax numbers:

9F. National Provider Identifier (NPI) number:

9G. Medical license number and state:

9H. Examiner's address: