Department of Veterans Affairs

AMPUTATIONS
DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran	Patient/Veteran's Social Security Number	Date of examination:

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 completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

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

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ 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.

DOMINANT HAND

Dominant hand: ◯ Right ◯ Left ◯ Ambidextrous

SECTION I - DIAGNOSIS

1A. Has the Veteran had any amputations?

◯ Yes ◯ No

1B. If yes, provide only diagnoses that pertain to amputations.

Amputation # 1 -		ICD code -		Date of amputation -	
Amputation # 2 -		ICD code -		Date of amputation -	
Amputation # 3 -		ICD code -		Date of amputation -	

1C. If additional amputation(s) exist, list using above format.

SECTION II - MEDICAL HISTORY

2A. Describe the history (including etiology and course) of each amputation listed above.

SECTION III - AMPUTATION(S) SITE(S)

3A. Amputation(s) sites(s) (Indicate affected sites):

☐ Upper extremities (not including the fingers)

☐ Fingers

☐ Lower extremities (not including the toes)

☐ Toes

For all checked sites, complete the corresponding sections below.

SECTION IV - UPPER EXTREMITIES (NOT INCLUDING FINGERS)

4A. Does the Veteran have an amputation of either arm?

◯ Yes ◯ No If yes, indicate site and side affected. Check all that apply.

☐ Amputation is below insertion of deltoid	◯ Left	◯ Right	◯ Both
☐ Amputation is above insertion of deltoid	◯ Left	◯ Right	◯ Both
☐ Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula)	◯ Left	◯ Right	◯ Both
☐ Forequarter amputation (involving complete removal of the humerus along with any portion of the clavicle)	◯ Left	◯ Right	◯ Both
☐ Forequarter amputation (involving complete removal of the humerus along with any portion of the ribs)	◯ Left	◯ Right	◯ Both
☐ Disarticulation (involving complete removal of the humerus only)	◯ Left	◯ Right	◯ Both

4B. Indicate if the upper extremity amputation site allows the use of a suitable prosthetic appliance.

Left ◯ Yes ◯ No ◯ NA

Right ◯ Yes ◯ No ◯ NA

4C. Is there an amputation of either forearm?

◯ Yes ◯ No If yes, indicate site and side affected. Check all that apply.

☐ Amputation below insertion of pronator teres ◯ Left ◯ Right ◯ Both

☐ Amputation above insertion of pronator teres ◯ Left ◯ Right ◯ Both

☐ Amputation resulting in loss of use of the hand ◯ Left ◯ Right ◯ Both

SECTION V - FINGERS

5A. Does the Veteran have an amputation of either thumb?

◯ Yes ◯ No If yes, indicate site and side affected. Check all that apply.

☐ Amputation at the distal joint or through the distal phalanx ◯ Left ◯ Right ◯ Both

☐ Amputation at the metacarpophalangeal joint or through the proximal phalanx ◯ Left ◯ Right ◯ Both

☐ Amputation with metacarpal resection ◯ Left ◯ Right ◯ Both

5B. Does the Veteran have an amputation of any fingers?

◯ Yes ◯ No If yes, indicate site and side affected. Check all that apply.

☐ Other (such as a fingertip amputation) please describe in Section VIII

☐ Amputation through the middle phalanx or at the distal joint

◯ Right index finger ◯ Right long finger ◯ Right ring finger ◯ Right little finger

◯ Left index finger ◯ Left long finger ◯ Left ring finger ◯ Left little finger

◯ Both index fingers ◯ Both long fingers ◯ Both ring fingers ◯ Both little fingers

☐ Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto

◯ Right index finger ◯ Right long finger ◯ Right ring finger ◯ Right little finger

◯ Left index finger ◯ Left long finger ◯ Left ring finger ◯ Left little finger

◯ Both index fingers ◯ Both long fingers ◯ Both ring fingers ◯ Both little fingers

☐ Amputation with metacarpal resection (more than one-half the bone lost)

◯ Right index finger ◯ Right long finger ◯ Right ring finger ◯ Right little finger

◯ Left index finger ◯ Left long finger ◯ Left ring finger ◯ Left little finger

◯ Both index fingers ◯ Both long fingers ◯ Both ring fingers ◯ Both little fingers

SECTION VI - LOWER EXTREMITIES (NOT INCLUDING THE TOES)

6A. Does the Veteran have an above the knee amputation of the thigh?

◯ Yes ◯ No If yes, indicate site and side affected. Check all that apply.

☐ Amputation of the middle or lower third ◯ Left ◯ Right ◯ Both

☐ Amputation of the upper third, one-third of the distance from the perineum to the knee joint, measured from the perineum ◯ Left ◯ Right ◯ Both

☐ Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only) ◯ Left ◯ Right ◯ Both

☐ Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones) ◯ Left ◯ Right ◯ Both

6B. Indicate if the thigh amputation site allows the use of a suitable prosthetic appliance.

Left ◯ Yes ◯ No ◯ NA

Right ◯ Yes ◯ No ◯ NA

6C. Does the Veteran have a below or through the knee amputation of the lower leg, including forefoot?

◯ Yes ◯ No If yes, indicate site and side affected. Check all that apply.

☐ Amputation of the forefoot, which is proximal to the metatarsal bones (more than one-half of metatarsal loss)	◯ Left	◯ Right	◯ Both
☐ Amputation between the forefoot and knee, permitting prosthesis	◯ Left	◯ Right	◯ Both
☐ Amputation not improvable by prosthesis controlled by natural knee action	◯ Left	◯ Right	◯ Both
☐ Amputation with defective stump and amputation of the thigh recommended	◯ Left	◯ Right	◯ Both

6D. Indicate if the lower leg amputation site allows the use of a suitable prosthetic appliance.

Left	◯ Yes	◯ No	◯ NA
Right	◯ Yes	◯ No	◯ NA

SECTION VII - TOES

7A. Does the Veteran have an amputation of any toes?

◯ Yes ◯ No If yes, indicate site and side affected. Check all that apply.

☐ Amputation of toes without metatarsal loss or transmetatarsal loss.

◯ Right great toe	◯ Right 2nd toe	◯ Right 3rd toe	◯ Right 4th toe	◯ Right little toe
◯ Left great toe	◯ Left 2nd toe	◯ Left 3rd toe	◯ Left 4th toe	◯ Left little toe
◯ Both great toes	◯ Both 2nd toes	◯ Both 3rd toes	◯ Both 4th toes	◯ Both little toes

☐ Amputation of toes with up to half metatarsal loss or transmetatarsal loss.

◯ Right great toe	◯ Right 2nd toe	◯ Right 3rd toe	◯ Right 4th toe	◯ Right little toe
◯ Left great toe	◯ Left 2nd toe	◯ Left 3rd toe	◯ Left 4th toe	◯ Left little toe
◯ Both great toes	◯ Both 2nd toes	◯ Both 3rd toes	◯ Both 4th toes	◯ Both little toes

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

8A. 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):

8B. Does the Veteran have any scars or other disfigurement of the skin related to any conditions or to the treatment of any conditions listed in the diagnosis section above?

◯ Yes ◯ No

If yes, also complete the appropriate dermatological questionnaire.

SECTION IX- ASSISTIVE DEVICES

9A. Does the Veteran use any assistive devices?

◯ Yes ◯ No

If Yes, identify the assistive devices 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

9B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

SECTION X - DIAGNOSTIC TESTING

Note - Imaging studies are not required to document amputations.

10A. Are there any significant diagnostic test findings and/or results?

◯ Yes ◯ No If yes, provide type of test or procedure, date and results - brief summary:

SECTION XI - 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.

11A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/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 XII - REMARKS

12A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

13A. Examiner's signature:	13B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

13C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	13D. Date Signed:

13E. Examiner's phone/fax numbers:	13F. National Provider Identifier (NPI) number:	13G. Medical license number and state:

13H. Examiner's address: