STATEMENT OF ATTENDING PHYSICIAN

RE: _____
Name of Veteran

Name of veteran must be given, whether statement is completed for veteran, widow, child or parent.

_____
VA Claim Number or Social Security Number

_____ _____
Name of Patient Address

Treatment Dates:_____ to_____

HISTORY OF ILLNESS:

SYMPTOMS, COMPLAINTS & FUNCTIONAL IMPAIRMENTS:

CLINICAL, LABORATORY, AND/OR X-RAY FINDINGS:
(or attach copies of clinical reports)

Please give results of any other examination, such as BMR, EKG,etc.

_____
Date of Exam

Pulse:_____ Blood Pressure:_____ S_____D_____

Height:_____ Weight:_____ Gait:_____

DIAGNOSIS: *(In arthritic cases, please indicate joints involved)*

Major Diagnosis:_____ Severity:_____

#2 Diagnosis: _____ Severity:_____

#3 Diagnosis: _____ Severity:_____

Is the patient in need of the Aid or Attendance of someone else in ordinary activities of daily living? Yes ☐ No ☐

Is the patient Housebound, i.e., confined to his or her house or immediate premises? Yes ☐ No ☐

If either answer is yes, complete the reverse side.

Date Signed:_____ Physician's Address: _____

Physician's Name:_____ _____
Signature of Physician

THIS WILL CERTIFY THAT I AM A DULY LICENSED PRACTICING PHYSICIAN.
All expenses incurred as a result of this exam are the responsibility of the veteran/claimant. Direct billing to this agency is not authorized.

Save Form

(To be completed if patient is housebound in need of aid and attendance)

DESCRIBE HOW OFTEN PER DAY OR WEEK, AND UNDER WHAT CIRCUMSTANCES, THE PATIENT IS ABLE TO LEAVE HIS HOME OR IMMEDIATE PREMISES:

ARE AIDS, SUCH AS A CANE, BRACES, CRUTCHES OR WALKER, REQUIRED FOR LOCOMOTION?

DESCRIBE RESTRICTIONS OF SPINE, TRUNK AND NECK, AND ANY RESTRICTION OF UPPER OR LOWER EXTREMITIES WITH REGARD TO LIMITATION OR MOTION, GRIP, FINE MOVEMENTS, ATROPHY, AND PROPULSION:

1.	Is patient bedridden?	**YES** ☐	**NO** ☐
2.	Is patient blind? corrected visual acuity OS_____ OD_____	**YES** ☐	**NO** ☐
3.	Is there complete loss of anal sphincter control?	**YES** ☐	**NO** ☐
4.	Is there complete loss of bladder sphincter control?	**YES** ☐	**NO** ☐
5.	Can patient walk and get around unassisted?	**YES** ☐	**NO** ☐
6.	Can patient undress and dress himself/herself unassisted?	**YES** ☐	**NO** ☐
7.	Can patient attend to the needs of nature unassisted?	**YES** ☐	**NO** ☐
8.	Can patient wash and keep himself/herself ordinarily clean and presentable?	**YES** ☐	**NO** ☐
9.	Is patient physically able to protect himself/herself from the everyday hazards of life?	**YES** ☐	**NO** ☐
10.	Is patient mentally able to protect himself/herself from everyday hazards of life?	**YES** ☐	**NO** ☐
11.	Is patient confined to a nursing home?	**YES** ☐	**NO** ☐
12.	Is the patient mentally capable of handling his/her financial affairs?**	**YES** ☐	**NO** ☐

** What mental condition prevents claimant from handling financial affairs?_____

If confined to nursing home or hospital, date of confinement:_____

If not currently confined, dates of last confinement:_____

Name and address of nursing home or hospital:_____

_____

ADDITIONAL REMARKS:

Save Form