



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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD AN ANKLE CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO ANKLE CONDITION(S):

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH

1C. IF THERE ARE ADDITIONAL DIAGNOSES PERTAINING TO ANKLE CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S ANKLE CONDITION (brief summary):

SECTION III - FLARE-UPS

3. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE ANKLE?

YES NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF THE IMPACT OF FLARE-UPS IN HIS OR HER OWN WORDS:

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. DURING THE MEASUREMENTS, DOCUMENT THE POINT AT WHICH PAINFUL MOTION BEGINS, EVIDENCED BY VISIBLE BEHAVIOR SUCH AS FACIAL EXPRESSION, WINCING, ETC. REPORT INITIAL MEASUREMENTS BELOW.

FOLLOWING THE INITIAL ASSESSMENT OF ROM, PERFORM REPETITIVE USE TESTING. FOR VA PURPOSES, REPETITIVE USE TESTING MUST BE INCLUDED IN ALL JOINT EXAMS. THE VA HAS DETERMINED THAT 3 REPETITIONS OF ROM (at a minimum) CAN SERVE AS A REPRESENTATIVE TEST OF THE EFFECT OF REPETITIVE USE. AFTER THE INITIAL MEASUREMENT, REASSESS ROM AFTER 3 REPETITIONS. REPORT POST-TEST MEASUREMENTS IN SECTION 5.

4A. RIGHT ANKLE PLANTAR FLEXION

SELECT WHERE PLANTAR FLEXION ENDS (normal endpoint is 45 degrees):

0 5 10 15 20 25 30 35 40 45 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

NO OBJECTIVE EVIDENCE OF PAINFUL MOTION

0 5 10 15 20 25 30 35 40 45 or greater

4B. RIGHT ANKLE DORSIFLEXION (extension)

SELECT WHERE DORSIFLEXION (extension) ENDS (normal endpoint is 20 degrees):

0 5 10 15 20 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

NO OBJECTIVE EVIDENCE OF PAINFUL MOTION

0 5 10 15 20 or greater

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS (Continued)

4C. LEFT ANKLE PLANTAR FLEXION

SELECT WHERE PLANTAR FLEXION ENDS (*normal endpoint is 45 degrees*):

0 5 10 15 20 25 30 35 40 45 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

NO OBJECTIVE EVIDENCE OF PAINFUL MOTION

0 5 10 15 20 25 30 35 40 45 or greater

4D. LEFT ANKLE PLANTAR DORSIFLEXION (*extension*)

SELECT WHERE DORSIFLEXION (*extension*) ENDS (*normal endpoint is 20 degrees*):

0 5 10 15 20 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

NO OBJECTIVE EVIDENCE OF PAINFUL MOTION

0 5 10 15 20 or greater

4E. IF ROM DOES NOT CONFORM TO THE NORMAL RANGE OF MOTION IDENTIFIED ABOVE BUT IS NORMAL FOR THIS VETERAN (*for reasons other than an ankle condition, such as age, body habitus, neurologic disease*), EXPLAIN:

SECTION V- ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

5A. IS THE VETERAN ABLE TO PERFORM REPETITIVE-USE TESTING WITH 3 REPETITIONS?

YES NO

IF UNABLE, PROVIDE REASON:

IF VETERAN IS UNABLE TO PERFORM REPETITIVE-USE TESTING, SKIP TO SECTION VI.

IF VETERAN IS ABLE TO PERFORM REPETITIVE-USE TESTING, MEASURE AND REPORT ROM AFTER A MINIMUM OF 3 REPETITIONS.

5B. RIGHT ANKLE POST-TEST ROM

SELECT WHERE POST-TEST PLANTAR FLEXION ENDS:

0 5 10 15 20 25 30 35 40 45 or greater

SELECT WHERE POST-TEST DORSIFLEXION (*extension*) ENDS:

0 5 10 15 20 or greater

5C. LEFT ANKLE POST-TEST ROM

SELECT WHERE POST-TEST PLANTAR FLEXION ENDS:

0 5 10 15 20 25 30 35 40 45 or greater

SELECT WHERE POST-TEST DORSIFLEXION (*extension*) ENDS:

0 5 10 15 20 or greater

SECTION VI- FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

THE FOLLOWING SECTION ADDRESSES REASONS FOR FUNCTIONAL LOSS, IF PRESENT, AND ADDITIONAL LOSS OF ROM AFTER REPETITIVE-USE TESTING, IF PRESENT. THE VA DEFINES FUNCTIONAL LOSS AS THE INABILITY TO PERFORM NORMAL WORKING MOVEMENTS OF THE BODY WITH NORMAL EXCURSION, STRENGTH, SPEED, COORDINATION AND/OR ENDURANCE.

6A. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE ANKLE FOLLOWING REPETITIVE-USE TESTING?

YES NO

6B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE ANKLE?

YES NO

SECTION VI- FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM (Continued)

6C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE ANKLE AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW (check all that apply and indicate side affected):

- No functional loss for right lower extremity attributable to claimed condition
- No functional loss for left lower extremity attributable to claimed condition
- Less movement than normal Right Left Both
- More movement than normal Right Left Both
- Weakened movement Right Left Both
- Excess fatigability Right Left Both
- Incoordination, impaired ability to execute skilled movements smoothly Right Left Both
- Pain on movement Right Left Both
- Swelling Right Left Both
- Deformity Right Left Both
- Atrophy of disuse Right Left Both
- Instability of station Right Left Both
- Disturbance of locomotion Right Left Both
- Interference with sitting, standing and weight-bearing Right Left Both
- Other, describe: _____

SECTION VII - PAIN (PAIN ON PALPATION)

7. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN ON PALPATION OF JOINTS/SOFT TISSUE OF EITHER ANKLE?

- YES NO IF YES, INDICATE SIDE AFFECTED: Right Left Both

SECTION VIII - MUSCLE STRENGTH TESTING

8. RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

- 0/5 No muscle movement
- 1/5 Palpable or visible muscle contraction, but no joint movement
- 2/5 Active movement with gravity eliminated
- 3/5 Active movement against gravity
- 4/5 Active movement against some resistance
- 5/5 Normal strength

- 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

SECTION IX - JOINT STABILITY

9A. ANTERIOR DRAWER TEST - IS THERE LAXITY COMPARED WITH OPPOSITE SIDE?

- YES NO UNABLE TO TEST
IF YES, WHICH SIDE DEMONSTRATES LAXITY? Right Left Both

9B. TALAR TILT TEST (inversion/eversion stress) - IS THERE LAXITY COMPARED WITH OPPOSITE SIDE?

- YES NO UNABLE TO TEST
IF YES, WHICH SIDE DEMONSTRATES LAXITY? Right Left Both

SECTION X - ANKYLOSIS

10. DOES THE VETERAN HAVE ANKYLOSIS OF THE ANKLE, SUBTALAR AND OR TARSAL JOINT?

- YES NO
- IF YES, INDICATE SEVERITY OF ANKYLOSIS AND SIDE AFFECTED (check all that apply):
- In plantar flexion, less than 30° Right Left Both
 - In plantar flexion, between 30° and 40° Right Left Both
 - In plantar flexion, at more than 40° Right Left Both
 - In dorsiflexion, between 0° and 10° Right Left Both
 - In dorsiflexion at more than 10° Right Left Both
 - With abduction, adduction, inversion or eversion deformity Right Left Both
 - In good weight-bearing position Right Left Both
 - In poor weight-bearing position Right Left Both

SECTION XI - ADDITIONAL CONDITIONS

11. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD "SHIN SPLINTS", STRESS FRACTURES, ACHILLES TENDONITIS, ACHILLES TENDON RUPTURE, MALUNION OF CALCANEUS (*os calcis*) OR TALUS (*astragalus*), OR HAS THE VETERAN HAD A TALECTOMY (*astragalectomy*)?

YES NO

IF YES, INDICATE CONDITION AND COMPLETE THE APPROPRIATE SECTIONS BELOW: _____

"SHIN SPLINTS" (*medial tibial stress syndrome*)

IF CHECKED, INDICATE SIDE AFFECTED: Right Left Both

DESCRIBE CURRENT SYMPTOMS: _____

STRESS FRACTURE OF THE LOWER EXTREMITY

IF CHECKED, INDICATE SIDE AFFECTED: Right Left Both

DESCRIBE CURRENT SYMPTOMS: _____

ACHILLES TENDONITIS OR ACHILLES TENDON RUPTURE

IF CHECKED, INDICATE SIDE AFFECTED: Right Left Both

DESCRIBE CURRENT SYMPTOMS: _____

MALUNION OF CALCANEUS (*os calcis*) OR TALUS (*astragalus*)

IF CHECKED, INDICATE SEVERITY AND SIDE AFFECTED:

Moderate Right Left Both

Marked deformity Right Left Both

TALECTOMY

IF CHECKED, INDICATE SIDE AFFECTED: Right Left Both

DESCRIBE CURRENT SYMPTOMS: _____

SECTION XII - JOINT REPLACEMENT AND OTHER SURGICAL PROCEDURES

12A. HAS THE VETERAN HAD A TOTAL ANKLE JOINT REPLACEMENT?

YES NO

IF YES, INDICATE SIDE AND SEVERITY OF RESIDUALS

Right ankle

Date of surgery: _____

Residuals:

None

Intermediate degrees of residual weakness, pain and/or limitation of motion

Chronic residuals consisting of severe painful motion and/or weakness

Other, describe: _____

Left ankle

Date of surgery: _____

Residuals:

None

Intermediate degrees of residual weakness, pain and/or limitation of motion

Chronic residuals consisting of severe painful motion and/or weakness

Other, describe: _____

12B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER ANKLE SURGERY?

YES NO

If yes, indicate side affected: Right Left Both

Date and type of surgery: _____

12C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER ANKLE SURGERY?

YES NO

If yes, indicate side affected: Right Left Both

If yes, describe residuals: _____

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

13A. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION 1, 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 39 SQUARE CM (6 square inches)?

YES NO (If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

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

13B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION 1, DIAGNOSIS?

YES NO

IF YES, DESCRIBE (*brief summary*):

SECTION XIV - ASSISTIVE DEVICES

14A. 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 |

14B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION XV - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

15. DUE TO THE VETERAN'S ANKLE CONDITION(S), 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 EXTREMITIES FOR WHICH THIS APPLIES:

- Right lower Left lower

FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES (*brief summary*):

SECTION XVI - DIAGNOSTIC TESTING

NOTE: The diagnosis of degenerative arthritis (*osteoarthritis*) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

16A. HAVE IMAGING STUDIES OF THE ANKLE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES NO

IF YES, ARE THERE ABNORMAL FINDINGS?

YES NO

IF YES, INDICATE FINDINGS:

- Degenerative or traumatic arthritis
ankle: Right Left Both
- Ankylosis
ankle: Right Left Both
- Other. Describe: _____
ankle: Right Left Both

16B. 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 XVII - FUNCTIONAL IMPACT

17. DOES THE VETERAN'S ANKLE CONDITION IMPACT HIS OR HER ABILITY TO WORK?

YES NO

IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S ANKLE CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION XVIII - REMARKS

18. REMARKS *(If any)*

SECTION XIX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

19A. PHYSICIAN'S SIGNATURE		19B. PHYSICIAN'S PRINTED NAME	19C. DATE SIGNED
19D. PHYSICIAN'S PHONE AND FAX NUMBER	19E. PHYSICIAN'S MEDICAL LICENSE NUMBER	19F. 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.vba.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.