



AMPUTATIONS 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 FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
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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.

NOTE: If the following are noted, complete the appropriate disability questionnaire.

1. For limited motion or instability in the joint above the amputation site, also complete the Disability Benefits Questionnaire for the specific joint.
2. For scars, or skin breakdown also complete the VA Form 21-0960F-1, Scars Disability Benefits Questionnaire.
3. For muscular injuries, also complete VA Form 21-0960M-10, Muscle Injury Disability Benefits Questionnaire.
4. For Osteomyelitis, also complete the VA Form 21-0960M-11, Osteomyelitis Disability Benefits Questionnaire.
5. For circulation conditions related to amputation, also complete VA Form 21-0960A-2, Arteries and Veins Disability Benefits Questionnaire.
6. For painful neuroma, also complete VA Form 21-0960C-1, Peripheral Nerve Disability Benefits Questionnaire.

SECTION I - DIAGNOSIS

1A. HAS AN AMPUTATION(S) BEEN PERFORMED?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO AMPUTATION(S)

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

2. DESCRIBE THE ETIOLOGY OF EACH AMPUTATION LISTED IN SECTION I:

SECTION III - DOMINANT HAND

3. DOMINANT HAND

RIGHT LEFT AMBIDEXTROUS

SECTION IV - AMPUTATION(S) SITE(S)

4. AMPUTATION(S) SITE(S) *(Check all that apply)*

- UPPER EXTREMITIES (not including the fingers)
- FINGERS
- LOWER EXTREMITIES (including the forefoot)
- TOES

(If checked, complete the appropriate section below)

NOTE - Imaging studies are not required to document amputation(s)

SECTION V - AMPUTATION(S) OF THE UPPER EXTREMITY(IES) (NOT INCLUDING FINGERS)

5A. IS THERE AN AMPUTATION OF EITHER ARM?

YES NO *(If "Yes," check all that apply)*

<input type="checkbox"/> LEFT <input type="checkbox"/> Amputation is below insertion of deltoid <input type="checkbox"/> Amputation is above insertion of deltoid <input type="checkbox"/> Disarticulation	<input type="checkbox"/> RIGHT <input type="checkbox"/> Amputation is below insertion of deltoid <input type="checkbox"/> Amputation is above insertion of deltoid <input type="checkbox"/> Disarticulation
Does the amputation site allow the use of a suitable prosthetic appliance? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does the amputation site allow the use of a suitable prosthetic appliance? <input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION V - AMPUTATION(S) OF THE UPPER EXTREMITY(IES) (NOT INCLUDING FINGERS) (Continued)

5B. IS THERE AN AMPUTATION OF EITHER FOREARM?

YES NO (If "Yes," check all that apply)

<input type="checkbox"/> LEFT <input type="checkbox"/> Amputation resulting in loss of use of the hand <input type="checkbox"/> Amputation below insertion of pronator teres <input type="checkbox"/> Amputation above insertion of pronator teres	<input type="checkbox"/> RIGHT <input type="checkbox"/> Amputation resulting in loss of use of hand <input type="checkbox"/> Amputation below insertion of pronator teres <input type="checkbox"/> Amputation above insertion of pronator teres
Does the amputation site allow the use of a suitable prosthetic appliance? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does the amputation site allow the use of a suitable prosthetic appliance? <input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION VI - AMPUTATION(S) OF FINGER(S)

6A. IS THERE AN AMPUTATION OF EITHER THUMB?

YES NO (If "Yes," check all that apply)

<input type="checkbox"/> LEFT <input type="checkbox"/> Amputation at the distal joint or through the distal phalanx <input type="checkbox"/> Amputation at the metacarpophalangeal joint or through the proximal phalanx <input type="checkbox"/> Amputation with metacarpal resection	<input type="checkbox"/> RIGHT <input type="checkbox"/> Amputation at the distal joint or through the distal phalanx <input type="checkbox"/> Amputation at the metacarpophalangeal joint or through the proximal phalanx <input type="checkbox"/> Amputation with metacarpal resection
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6B. IS THERE AN AMPUTATION OF EITHER INDEX FINGER?

YES NO (If "Yes," check all that apply)

<input type="checkbox"/> LEFT <input type="checkbox"/> Amputation through the long phalanx or at the distal joint <input type="checkbox"/> Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto <input type="checkbox"/> Amputation with metacarpal resection (more than one-half the bone lost)	<input type="checkbox"/> RIGHT <input type="checkbox"/> Amputation through the long phalanx or at the distal joint <input type="checkbox"/> Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto <input type="checkbox"/> Amputation with metacarpal resection (more than one-half the bone lost)
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6C. IS THERE AN AMPUTATION OF EITHER LONG FINGER?

YES NO (If "Yes," check all that apply)

<input type="checkbox"/> LEFT <input type="checkbox"/> Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto <input type="checkbox"/> Amputation with metacarpal resection (more than one-half the bone lost)	<input type="checkbox"/> RIGHT <input type="checkbox"/> Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto <input type="checkbox"/> Amputation with metacarpal resection (more than one-half the bone lost)
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6D. IS THERE AN AMPUTATION OF EITHER RING FINGER?

YES NO (If "Yes," check all that apply)

<input type="checkbox"/> LEFT <input type="checkbox"/> Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto <input type="checkbox"/> Amputation with metacarpal resection (more than one-half the bone lost)	<input type="checkbox"/> RIGHT <input type="checkbox"/> Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto <input type="checkbox"/> Amputation with metacarpal resection (more than one-half the bone lost)
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6E. IS THERE AN AMPUTATION OF EITHER LITTLE FINGER?

YES NO (If "Yes," check all that apply)

<input type="checkbox"/> LEFT <input type="checkbox"/> Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto <input type="checkbox"/> Amputation with metacarpal resection (more than one-half the bone lost)	<input type="checkbox"/> RIGHT <input type="checkbox"/> Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto <input type="checkbox"/> Amputation with metacarpal resection (more than one-half the bone lost)
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SECTION VII - AMPUTATION(S) OF THE LOWER EXTREMITY(IES) (NOT INCLUDING THE TOES)

7A. IS THERE AN AMPUTATION ABOVE EITHER KNEE?

YES NO (If "Yes," check all that apply)

<input type="checkbox"/> LEFT <input type="checkbox"/> Amputation of the middle or lower third <input type="checkbox"/> Amputation of the upper third, one-third of the distance from the perineum to the knee joint, measured from the perineum <input type="checkbox"/> Disarticulation with loss of extrinsic pelvic girdle muscles	<input type="checkbox"/> RIGHT <input type="checkbox"/> Amputation of the middle or lower third <input type="checkbox"/> Amputation of the upper third, one-third of the distance from the perineum to the knee joint, measured from the perineum <input type="checkbox"/> Disarticulation with loss of extrinsic pelvic girdle muscles
Does the amputation site allow the use of a suitable prosthetic appliance? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does the amputation site allow the use of a suitable prosthetic appliance? <input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION VII - AMPUTATION(S) OF THE LOWER EXTREMITY(IES) (NOT INCLUDING THE TOES) (Continued)

7B. IS THERE AN AMPUTATION BELOW EITHER KNEE (TO INCLUDE FOREFOOT)?

YES NO (If "Yes," check all that apply)

<p><input type="checkbox"/> LEFT</p> <p><input type="checkbox"/> Amputation of the forefoot, which is proximal to the metatarsal bones (more than one-half of metatarsal loss)</p> <p><input type="checkbox"/> Amputation at a lower level (between the forefoot and knee), permitting prosthesis</p> <p><input type="checkbox"/> Amputation not improvable by prosthesis controlled by natural knee action</p> <p><input type="checkbox"/> Amputation with defective stump and amputation of the thigh recommended</p>	<p><input type="checkbox"/> RIGHT</p> <p><input type="checkbox"/> Amputation of the forefoot, which is proximal to the metatarsal bones (more than one-half of metatarsal loss)</p> <p><input type="checkbox"/> Amputation at a lower level (between the forefoot and knee), permitting prosthesis</p> <p><input type="checkbox"/> Amputation not improvable by prosthesis controlled by natural knee action</p> <p><input type="checkbox"/> Amputation with defective stump and amputation of the thigh recommended</p>
<p>Does the amputation site allow the use of a suitable prosthetic appliance?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Does the amputation site allow the use of a suitable prosthetic appliance?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

SECTION VIII - AMPUTATION(S) OF THE TOE(S)

8. IS THERE AN AMPUTATION OF A TOE(S) OF EITHER FOOT?

YES NO (If "Yes," check all that apply)

<p><input type="checkbox"/> LEFT</p> <p>Is there amputation of all toes without metatarsal loss? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Is there amputation of the great toe? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(If "Yes," indicate which of the following apply):</p> <p><input type="checkbox"/> Amputation without metatarsal involvement</p> <p><input type="checkbox"/> Amputation with removal of the metatarsal head</p> <p>Is there amputation of any lesser toe with removal of the metatarsal head? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(If "Yes," indicate which of the following apply):</p> <p><input type="checkbox"/> Amputation of toes one or two</p> <p><input type="checkbox"/> Amputation without metatarsal involvement</p> <p>Is there amputation of toes three or four without metatarsal involvement? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(If "Yes," indicate which of the following apply):</p> <p><input type="checkbox"/> Amputation not including great toe</p> <p><input type="checkbox"/> Amputation including great toe</p>	<p><input type="checkbox"/> RIGHT</p> <p>Is there amputation of all toes without metatarsal loss? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Is there amputation of the great toe? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(If "Yes," indicate which of the following apply):</p> <p><input type="checkbox"/> Amputation without metatarsal involvement</p> <p><input type="checkbox"/> Amputation with removal of the metatarsal head</p> <p>Is there amputation of any lesser toe with removal of the metatarsal head? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(If "Yes," indicate which of the following apply):</p> <p><input type="checkbox"/> Amputation of toes one or two</p> <p><input type="checkbox"/> Amputation without metatarsal involvement</p> <p>Is there amputation of toes three or four without metatarsal involvement? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(If "Yes," indicate which of the following apply):</p> <p><input type="checkbox"/> Amputation not including great toe</p> <p><input type="checkbox"/> Amputation including great toe</p>
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SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

9A. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, 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)

9B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

YES NO (If "Yes," describe (Brief summary))

SECTION X - ASSISTIVE DEVICES

10A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE? *(If "Yes," identify assistive devices used - check all that apply and indicate frequency)*

- YES NO
- 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 ASSISTIVE DEVICE USED FOR EACH CONDITION

SECTION XI - DIAGNOSTIC TESTING

NOTE - Imaging studies are not required to document amputation(s)

11. 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 XII - FUNCTIONAL IMPACT

12. DOES THE VETERAN'S AMPUTATION IMPACT HIS OR HER ABILITY TO WORK?

- YES NO *(If "Yes," describe the impact of each of the veteran's amputations providing one or more examples)*

SECTION XIII - REMARKS

13. REMARKS *(If any)*

SECTION XIV - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

14A. PHYSICIAN'S SIGNATURE	14B. PHYSICIAN'S PRINTED NAME	14C. DATE SIGNED
14D. PHYSICIAN'S PHONE AND FAX NUMBER	14E. PHYSICIAN'S MEDICAL LICENSE NUMBER	14F. 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.