OMB Approved No. 2900-0749
Respondent Burden: 15 minutes
Expiration Date: 06/30/2020

Department of Veterans Affairs

PARKINSON'S DISEASE 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 ON REVERSE 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 use the information you provide on this questionnaire to process the Veteran's claim. VA reserves the right to confirm the authenticity of ALL DBQ's completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH PARKINSON'S DISEASE?	1B. ICD CODE(S)	1C. DATE OF DIAGNOSIS
☐ YES ☐ NO		

2. DOMINANT HAND

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION II - MOTOR MANIFESTATIONS

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

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

F. 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

G. 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

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III - MENTAL MANIFESTATIONS

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

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

SECTION IV - ADDITIONAL MANIFESTATIONS/COMPLICATIONS

5. ADDITIONAL MANIFESTATIONS/COMPLICATIONS DUE TO PARKINSON'S OR ITS TREATMENT *(Check all that apply)*

ADDITIONAL MANIFESTATIONS/COMPLICATIONS	NONE	MILD	MODERATE	SEVERE
A. LOSS OF SENSE OF SMELL ☐ PARTIAL ☐ COMPLETE	☐			
B. SLEEP DISTURBANCE *(Insomnia or daytime "sleep attacks")*	☐	☐	☐	☐
C. DIFFICULTY CHEWING/SWALLOWING	☐	☐	☐	☐
D. URINARY PROBLEMS *(Incontinence or urinary retention) - (Indicate "None" or, if absorbent material required due to incontinence, specify pads/day):* ☐ 0 ☐ 1 ☐ 2-4 ☐ >4 ☐ OR, IF APPLICABLE, USE OF AN APPLIANCE	☐			
E. CONSTIPATION *(DUE TO SLOWING OF GI TRACT OR SECONDARY TO PARKINSON'S MEDICATIONS)*	☐	☐	☐	☐
F. SEXUAL DYSFUNCTION	☐	☐	☐	☐ *(Precludes intercourse, including erectile dysfunction)*
G. OTHER MANIFESTATIONS/COMPLICATIONS *(Specify):*	☐	☐	☐	☐
H. OTHER MANIFESTATIONS/COMPLICATIONS *(Specify):*	☐	☐	☐	☐

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 V - FUNCTIONAL IMPACT AND REMARKS

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

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

PATIENT/VETERAN'S SOCIAL SECURITY NO. ___ - __ - ____

SECTION V - FUNCTIONAL IMPACT AND REMARKS (Continued)

8. REMARKS *(If any)*

SECTION VI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE *(Sign in ink)*	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBER	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain additional medical information, including an examination, 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.benefits.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, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. 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 15 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.