Form 1 -- Statement of Attending Physician

This report is used to determine if the patient has an ongoing need for aid and attendance from another person or if the patient is housebound -- confined to his or her immediate premises. In order to assign a disability rating of "aid and attendance" or "housebound", the Veterans Affairs Regional Office will consider medical evidence indicating one or more of the following conditions:

- patient is unable to dress or undress, or to keep himself or herself ordinarily clean and presentable;
- patient is bedridden, blind or severely visually impaired;
- patient is unable to feed himself or herself through loss of coordination of upper extremities or through extreme weakness;
- patient is unable to attend to the wants of nature;
- patient has an incapacity, physical or mental, which requires care or assistance on a regular basis to protect the patient from hazards or dangers incident to his or her daily environment;
- patient needs to be in a protective environment due to cognitive impairment or other condition.

Name of Patient Requesting Exam for Rating (Name of Veteran or Spouse of Veteran)	Name of Veteran (For VA Purposes)	Veteran's SSN or VA Case #

Address of Patient Requesting Exam for Rating	City	State	Zip	Contact Phone

Date of Examination	Name, Complete Address, and Phone Number of Contact Person (if Additional Records are Requested)

History of Diseases, Injuries, or Conditions that Directly Contribute to Patient's Disabilities

Specific Diagnoses

Age	Sex	Weight	Height	Blood Pressure	Pulse Rate	Hours in Bed per Day	Respiratory Rate

Posture and General Appearance	Nutrition	Gait

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:

CONTINUE ON THE OTHER SIDE

Set forth all other pathology including the loss of bowel or bladder control or the effects of advancing age, such as dizziness, loss of memory, poor balance which affects claimant's ability to perform self-care, ambulate or travel beyond the premises of the home or if hospitalized beyond the ward or clinical area. Describe where the claimant goes and what he or she does during a typical day.

Can claimant walk without the help of another person? (if "yes," give distance)	YES	NO	1 BLOCK	5 OR 6 BLOCKS	1 MILE	OTHER

Are aids such as canes, braces, crutches, or walkers required for locomotion? *(if so, specify and describe effectiveness in terms of distance that can be traveled as in item above)*

Describe how often per day or week and under what circumstances the individual is able to leave the home or immediate premises.

Additional remarks

Please answer below "yes" or "no"	Yes	No	Please answer below "yes" or "no"	Yes	No
Is patient bedridden?			Can patient keep himself ordinarily clean and presentable?		
Is patient blind or severely visually restricted ?			Can patient physically protect himself from everyday hazards of life?		
Is there complete loss of anal sphincter control?			Can patient mentally protect himself from everyday hazards of life?		
Is there complete loss of bladder sphincter control?			Does patient need help feeding himself or herself?		
Can patient walk and get around unassisted?			Is patient confined to a nursing home or hospital?		
Can patient undress and dress unassisted?			If confined to a nursing home or hospital, date of confinement:		
Can patient attend to the needs of nature unassisted?			Name and address of nursing home or hospital:		

Date Signed:_____ **Physician's Address:** _____

Physician's Name: _____ **Signature of Physician:**_____

THIS WILL CERTIFY THAT I AM A DULY LICENSED PRACTICING PHYSICIAN.

MEDICAL STATEMENT FOR CONSIDERATION OF AID & ATTENDANCE

(Please circle the appropriate answer and explain each in detail.)

RETURN ADDRESS:

*VA FILE NO.*_____

VETERAN'S NAME: _____
Last First Middle

CLAIMANT'S NAME: _____
Last First Middle

1. Complete Diagnosis:_____

_____

_____

2. Is the claimant able to walk unaided? Yes No

Explanation:_____

_____

3. Is the claimant able to feed him/herself? Yes No

Explanation (including, how far):_____

_____

4. Does the claimant need assistance in bathing and tending to other hygiene needs? Yes No

5. Is the claimant able to care for the needs of nature? Yes No

Explanation:_____

_____

6. Is the claimant confined to bed? Yes No

Explanation:_____

_____

7. Is the claimant able to sit up? Yes No

Explanation:_____

_____

8. Is the claimant blind? Yes No

Corrected Vision: L_____ R_____

Explanation:_____

_____

9. Is the claimant able to travel? Yes No

Explanation:_____

_____

10. Can the claimant leave home without assistance? Yes No
(If yes, how far can he/she go?(List distance)

Explanation:_____

_____

11. Does the claimant require nursing home care? Yes No

Explanation:_____

_____

12. In your opinion, are there other pertinent facts which would show the claimant's need for aid and attendance of another person, e.g., inability to protect oneself from the hazards of environment, properly dress oneself (buttons, zippers, socks), poor balance, memory loss, confusion, psychiatric impairment, atrophy, contractor, prosthesis, etc? _____

_____

_____

_____

**** If possible, please attach copies of office or hospital records concerning the claimant's recent medical history.**

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.
PHYSICIAN'S NAME & ADDRESS
(Please type or print)

_____ _____
(Examining Physician's Signature)

_____

_____

**Billing Information:
All expenses incurred as a result of this exam are the responsibility of the veteran/claimant. Direct billing to this agency is not authorized.