Physician's Statement
In Support of Claim for Housebound or A&A Benefits

VA FILE NUMBER:____

SOCIAL SECURITY #:______________________________________

NAME OF CLAIMANT:_____________________________________

Indicate if the claimant is competent to handle his/her own legal and financial affairs. If the claimant is not competent, please state the specific diagnosis affecting competency.

1. ***GENERAL*****: (**Describe posture and general appearance)

Diagnosis:

2. ***UPPER EXTREMITIES*****:** (Describe restrictions of each upper extremity)

3. ***LOWER EXTREMITIES:*** (Describe restriction of each lower extremity, with reference to extent of limitation of motion, atrophy, contractures or other interference, also if affected, please comment on weight bearing, balance, and propulsion of each lower extremity)

4. ***SPINE*****:** (Describe restriction of the spine, trunk and neck)

5. ***OTHER*****:** (Set forth all other pathology including the effects of advancing age, such as dizziness, loss of memory, poor balance, which affects the claimant's ability to perform self-care, ambulate, or travel.)

Indicate which of the below functions the claimant is <u>unable or requires assistance</u> in performing:

Dress and undress

Keep clean and presentable

Eat Meals

Attend to the needs of nature

6. ***AMBULATION*****:** Indicate if the claimant can walk <u>without</u> ambulatory aids or the assistance of another person, and if so, indicate distance:

If ambulatory aids are required for locomotion, what aids are utilized (cane, braces, crutches, walker, etc.)? Also indicate the distance the claimant can walk with the aid.

State if the claimant is restricted to his/her immediate premises, and if bedridden, indicate the number of hours per day spent in bed.

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

7. ***OTHER INFORMATION*****:** (Is the claimant blind? If so, indicate best corrected visual acuity)

_______________________________ _______________
Name and signature of physician Date

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Date of last examination or treatment