Department of Veterans Affairs

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

(For VA Use Only)

1. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT	2. VA FILE NUMBER	
3. HOME ADDRESS	4. PLACE OF EXAMINATION	5. DATE OF EXAMINATION

6. WAS CLAIMANT ACCOMPANIED TO PLACE OF EXAMINATION? ☐ YES ☐ NO *(If "Yes," complete Items 7 and 8)*	7. NAME OF NURSE OR ATTENDANT	8. MODE OF TRAVEL
9. IS CLAIMANT HOSPITALIZED? ☐ YES ☐ NO *(If "Yes," complete Items 10 and 11)*	10. DATE ADMITTED	11. NAME AND ADDRESS OF HOSPITAL

NOTE: VA MEDICAL EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound or in need of the regular aid and attendance of another person.

Findings should be recorded to show whether the claimant is blind or bedridden.

The report should be in sufficient detail for the regional office rating board to determine whether there is disease or injury producing physical or mental impairment, loss of coordination or enfeeblement affecting ability to dress and undress, for self feeding, to attend to the wants of nature and keep him/herself ordinarily clean and presentable.

In addition, it is necessary to state findings indicating whether the claimant is "housebound", that is whether he/she is confined to the home or immediate premises.

In either instance, whether the claimant is claiming housebound or aid and attendance benefits, the report should reflect how well the individual ambulates, where the individual goes, and what he/she is able to do during a typical day.

12. INDIVIDUAL'S COMPLAINT

13A. AGE	13B. SEX	14. WEIGHT ACTUAL: LBS: ESTIMATED: LBS.	15. HEIGHT FT: INCHES
16. NUTRITION			17. GAIT

18. BLOOD PRESSURE	19. PULSE RATE	20. RESPIRATORY RATE	21. NUMBER OF HOURS IN BED FROM 9 PM TO 9 AM: FROM 9 AM TO 9 PM:

22. POSTURE AND GENERAL APPEARANCE

23. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY FOR SELF FEEDING, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE.

24. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO EXTENT OF LIMITATION OF MOTION, ATROPHY, CONTRACTURES OR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

25. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

26. 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.

27. IS THE CLAIMANT ABLE TO WALK WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

☐ YES ☐ NO *(If "YES," give distance)* ☐ 1 BLOCK ☐ 5 0R 6 BLOCKS ☐ 1 MILE ☐ OTHER (Specify distance)

28. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE INDIVIDUAL IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

29. 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 traveledas in Item 27 above)*

30. ADDITIONAL REMARKS

31. DIAGNOSIS

32. CERTIFICATION OF NEED FOR HIGHER LEVEL AID AND ATTENDANCE (38 U.S.C. 314 (r)(2))
(To be completed only when determination is requested by Adjudication)

I HEREBY CERTIFY THAT

☐ VETERAN REQUIRES THE DAILY PERSONAL HEALTH CARE SERVICES OF A SKILLED PROVIDER WITHOUT WHICH THE VETERAN WOULD REQUIRE HOSPITAL, NURSING HOME OR OTHER INSTITUTIONAL CARE

☐ DAILY SKILLED SERVICES NOT INDICATED

33. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	34. VA HOSPITAL OR OTHER MEDICAL FACILITY