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

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 his/herself? Yes No

Explanation:_____

_____

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?_____

_____

_____

**** If possible, please attach copies of office or hospital records concerning the claimants 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.