

**MEDICAL STATEMENT FOR CONSIDERATION FOR AID AND ATTENDANCE
OR HOUSEBOUND FOR VETERAN OR AID AND ATTENDANCE FOR WIDOW, WIDOWER, SPOUSE**
(For additional space, please use back of form.)

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 VA 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.

1. NAME OF VETERAN _____ VA FILE NO. _____
2. NAME OF CLAIMANT _____ AGE _____
3. ADDRESS OF CLAIMANT _____
4. PLACE OF EXAMINATION: DOCTOR'S OFFICE () HOSPITAL () CLAIMANT'S HOME () NURSING HOME ()
5. DIAGNOSES _____
6. PROGNOSIS _____
7. Describe:
 - a. Restrictions relating to upper and lower extremities and fine movements;
 - b. Ability to feed himself/herself, attend to the needs of nature, button clothing, and care for personal needs alone;
 - c. If visually impaired - the best corrected visual acuity in each eye. L. _____ R. __________
8. Describe: Conditions which prevent self-care, cause loss of balance, cause loss of mental ability or functions, and restrict claimant's travel or mobility.

9. Is claimant mentally competent to manage his/her own affairs. Yes () No ()
10. Distance claimant can walk without assistance from another person.
None () Confined to Home () Other () Please specify _____
11. Claimant requires the use of the following:
Bed () Please state amount of time in each 24 hour period: _____
Wheelchair () Cane, braces or walker Please specify _____
Other specialized equipment () Please specify _____
12. Is the claimant a patient in a nursing home? Yes () No ()
 - a. Date of Admission _____
 - b. Name and Address of Nursing Home _____If no, should claimant be in a nursing home and why? _____
13. Why does the claimant require the care or assistance of another person? _____

Date

Signature of Examining Physician

Address