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| Australian Government crest, Department of Veterans' Affairs branding | Foot and Toe Condition(s)Medical Impairment Assessment |
| Veteran |  | UIN |
|  |  |  |
|  |  |  |
| Please assess the following conditions:  |
|  |  |  |

1. Please select the most accurate description of loss of **active Range of Movement (RoM) of the hallux**. Rate the worst of the interphalangeal (IP) or metatarsophalangeal (MTP) joints.

| **Description** | **Right** | **Left** |
| --- | --- | --- |
| **Incomplete loss** of movement. |[ ] [ ]
| **Ankylosis** in **favourable position** of any joint. |[ ] [ ]
| **Ankylosis** in an **unfavourable position** of any joint OR a **flail joint**. |[ ] [ ]

1. Please select the **most severe restriction of RoM** of **any other toe(s)**.

| **Description** | **Right** | **Left** |
| --- | --- | --- |
| **Incomplete loss** of movement. |[ ] [ ]
| **Ankylosis.** |[ ] [ ]

1. Please select the most accurate description of any **resting joint pain** (pain which is present in the absence of use of the joint, or which persists beyond the expected recovery period). Do not include pain that is not related to a joint.

| **Description** | **Right** | **Left** |
| --- | --- | --- |
| None or **not usually present** at rest. |[ ] [ ]
| **Mild** pain that is **often present** at rest. |[ ] [ ]
| Pain that is **often** **present** at rest but **improves** after several hours or responds to medication or to therapeutic measures. |[ ] [ ]
| **Severe** pain that is **often present** at rest but **does not respond adequately** to medication or to therapeutic measures. |[ ] [ ]
| **Severe** pain that is **always present** at rest but **does not respond adequately** to medication or therapeutic measures AND **regularly interferes with sleep**. |[ ] [ ]

1. Does the veteran have **symptoms** of any of the following conditions? Please select **all** that apply.

| **Description** | **No Symptoms** | **Right** | **Left** |
| --- | --- | --- | --- |
| Pes planus. |[ ] [ ] [ ]
| Hammer toes. |[ ] [ ] [ ]
| Claw toes. |[ ] [ ] [ ]
| Hallux valgus. |[ ] [ ] [ ]
| Calcaneal spurs. |[ ] [ ] [ ]

1. Please list **all conditions** contributing to the reported impairment to the **loss of ROM at Q1 and Q2** and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

| **Condition** | **Contribution %** |
| --- | --- |
| e.g. Hallux rigidus right side | 75% |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total** | **100%** |

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| --- | --- | --- | --- |
| Doctor's signature | Doctor's name | Date | Time to complete form |
|  |  |  |  |