Australian Government
Department of Veterans' Affairs

Cranial Nerves
Medical Impairment Assessment

Veteran	UIN

Please assess the following conditions:

1. Please select the most accurate description of any difficulty with **smell**.

Description	Select One
Normal.	☐
Partial loss of sense of smell (please estimate % loss).	%
Complete neurological loss.	☐

2. Please select the most accurate description of any **visual field** defects.

Description	Right Eye	Left Eye
Normal fields.	☐	☐
Hemianopia (indicate if homonymous, binasal or bitemporal).	.....	
Other visual field loss (please provide % loss).	%	%

3. Please describe any abnormal function of the 3rd, 4th or 6th cranial nerves:

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4. Please select the most accurate description of any **trigeminal neuralgia**.

Description	Select One
None.	☐
Intermittent pain.	☐
Pain occurs frequently (on most days).	☐

5. Please identify any impairment of **trigeminal sensory** function (one selection for each side).

Description	Right CN V	Left CN V
Normal.	☐	☐
Partial sensory loss (please estimate % loss).	%	%
Complete sensory loss of one division.	☐	☐
Complete sensory loss of 2 divisions.	☐	☐
Complete sensory loss of all 3 divisions.	☐	☐

6. Please select the most accurate description of any impairment of **taste**.

Description	Select One
Normal.	☐
Abnormal taste (e.g. metallic flavour).	☐
Partial loss of taste (please estimate % loss).	%
Complete bilateral loss.	☐

7. Please select the most accurate description of any impairment of **facial expression**.

Description	Right CN VII	Left CN VII
Normal.	☐	☐
Partial paralysis (please estimate % loss).	%	%
Complete paralysis.	☐	☐

8. Please select the most accurate description of any difficulty with **chewing and/or swallowing**.

Description	Select One
Normal.	☐
Some difficulty but only minor or occasional restriction of diet.	☐
Significant difficulty chewing and/or constant dysphagia. There is some modification of diet but it is not grossly restricted.	☐
Diet is limited to soft or semi-solid foods.	☐
Diet is limited to liquid or pureed foods.	☐
Gastrostomy or nasogastric tube feeding.	☐

9. Please describe the nature and severity of any difficulty with **speech**:

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10. Please select the most accurate description of any impairment with **shoulder elevation**.

Description	Right CN XI	Left CN XI
Normal.	☐	☐
Partial loss (please estimate % loss).	%	%
Complete.	☐	☐

11. Please describe any other relevant findings:

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12. Please list **all conditions** contributing to the reported impairment 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. R MCA stroke	75%
Total	**100%**

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

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