



Veteran

UIN

Insert conditions:

For this assessment, each condition needs to be assessed in **isolation** from all others. This means that when assessing a condition, you will need to assess the impairment **as though only that single condition is present**, and that the veteran is otherwise healthy and normal. If it is not possible to separate the impairment in this way, please select a description of the total impairment rating under "combined conditions."

For the purposes of this form, "difficulty" refers to an activity being hard to perform, because of an actual, observable limitation or impediment. Difficulty may be evident through the use of splints, aids, rails, or personal assistance, or through the exertion of additional effort to complete the task. Voluntary avoidance of physical activity to minimise pain cannot be considered. Where possible, your assessment should be based on your observation and examination of the veteran, as well as their history and any relevant investigations.

1. Please select the most accurate description of impairment to **active range of movement (ROM) of the cervical spine**, due to each condition *in isolation*. Consider motion in all planes of movement.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	Combined Conditions (if unable to isolate)
None or x-ray changes only.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minor or loss of less than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of more than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complete loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR

2. Please select the most accurate description of any difficulty with **digital dexterity**, due to each condition *in isolation*.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	OR	Combined Conditions (if unable to isolate)
No difficulty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Some difficulty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Complete loss of digital dexterity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

3. Please select the most accurate description of any difficulty with **grasping and holding**, due to each condition *in isolation*.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	OR	Combined Conditions (if unable to isolate)
No difficulty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Some difficulty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Completely unable to grasp or hold.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

4. Please select the most accurate description of any difficulty with **using the affected limb(s) for self-care**, due to each condition *in isolation*.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	OR	Combined Conditions (if unable to isolate)
No difficulty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Some difficulty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Completely unable to use the affected limb(s) for self-care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

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