

# DEMO Traumatic Brain Injury Examination Course

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# Introduction

## Welcome

**\*\*Disclaimer\*\*** It is important to note that this course only provides basic information about conducting a TBI examination. Determination of causality of residual symptoms is a complex issue. In addition to this introduction, ongoing CME related to TBI is recommended to further competency in conducting TBI evaluations.

## Welcome

This course is a joint presentation of the Disability Examination Management Office (DEMO), Veterans Health Administration (VHA), and Employee Education System (EES). In this training, we will focus on the initial compensation and pension (C&P) exam for traumatic brain injury (TBI). TBI may produce a complex constellation of medical consequences including physical, emotional, behavioral, and cognitive deficits. The impact is heterogeneous given the varied types of injury (closed, penetrating, blast), severity, comorbid conditions, and premorbid characteristics. Furthermore, when assessing, the practitioner must consider the impact of psychosocial factors.

This training will discuss the eligibility requirements and reasons for conducting a TBI examination and why it is important to gather historical, personal, and medical information about the Veteran or Servicemember. We will also look at a Disability Benefits Questionnaire (DBQ) and other specific medical information needed to reach a legal decision about a Veteran's or Servicemember's entitlement or non-entitlement for benefits, based on his or her disability.

## What You Will Learn

This training is designed for physicians, nurses, psychologists, Integrated Disability Evaluation System (IDES) providers and other health care providers seeking certification to conduct C&P examinations.

## Target Audience

This training is designed for physicians, nurses, psychologists, Integrated Disability Evaluation System (IDES) providers and other health care providers seeking certification to conduct C&P examinations.

## Additional Course Information

### Length of the Course

This course will take you approximately one hour to complete.

Please complete each lesson in the order presented. By doing so, you will be able to build on that knowledge in subsequent lessons.

## Compensation and Pension Terminology

This course will provide basic information about the context that you will work within as a disability examiner for Initial TBI. Acronyms will be spelled out the first time they appear and will also be listed in the Glossary.

You can access the Glossary in the Resources section of this course by selecting Resources at the bottom of this screen.

## Course Purpose, Terminal and Enabling Objectives

### Terminal Learning Objective

At the completion of this training, you should be able to identify the criteria and recall the general process for opening, conducting, closing, and documenting a C&P TBI Examination. This course will include the use of a condition-specific DBQ or other documentation protocol in order to assess the presence and extent of impairment due to service-connected conditions according to Disability Management Assessment (DMA) and DEMO policy guidance consistent with VBA's regulations, manuals, policies, directives, and guidelines.

### Enabling Learning Objectives

To help you meet this objective, there are eight enabling learning objectives:

1. Define the criteria to diagnose TBI.
2. Describe best practices for activities performed prior to conducting a C&P TBI examination.
3. Apply best practices for opening, conducting, and closing a C&P TBI examination.
4. Apply best practices for guiding the Veteran or Servicemember through the interview and examination process.
5. Identify signs and symptoms of TBI sequelae.
6. Explain when additional testing is indicated.
7. Incorporate the interpretation of diagnostic tests into the C&P report.
8. Apply best practices for using the DBQ or other documentation protocol to document a C&P TBI examination.

The standards for this course are found in federal regulations; VA directives; and manuals from VHA, VBA, Board of Veterans' Appeals (BVA); and in guidance from the DEMO.

## Case Study

**This case study is of a fictitious Veteran. It is not intended to reflect the life or situation of any Veteran or Servicemember.**

Mr. Smith is a 25 year-old Marine Corps Veteran. He was deployed most recently to Afghanistan from August through November of 2010 and has filed a claim for TBI. Following best practices, you will review his Request for Examination (2507), information from his Claims File (C-file), and the documentation protocol for the exam as though you were his examiner. You will also review highlights from his examination and will have opportunities to compare your documentation from this exam with the documentation that the examiner produces.

# Traumatic Brain Injury Examinations

## Learning Objective

As you may recall, the purpose of an exam for treatment is to provide a diagnosis and appropriate treatment for the party you examine. On the other hand, a Compensation and Pension (C&P) disability exam has the purpose of providing diagnostic and other clinical evidence concerning the severity of a disability needed by Veterans Benefits Administration (VBA) to determine entitlement to benefits for the party you examine. Your role as a disability examiner is a critical step in a process that starts and ends with the Veteran or Servicemember in front of you. Consistent, high-quality C&P examinations are essential to ensure that Veterans and Servicemembers are evaluated fairly—and consistently—as part of the benefits claims process. Traumatic brain injury (TBI) examinations are an important part of the C&P process. We will begin by providing some background on what constitutes a TBI. When you complete this lesson, you should be able to define the criteria to diagnose TBI.

Now, let's get started.

## Unique Aspects of the C&P Legal Forensic Examination

A clinical examination for treatment can be scheduled by a patient with the purpose of providing a diagnosis and appropriate treatment. The audience for the documentation you provide from an examination for treatment would be primarily other clinicians. By comparison, the C&P disability examination is requested by the Department of Defense (DOD) or VBA when clinical information is needed to determine entitlement to benefits for the person you examine. The audience for the documentation you provide from a C&P examination is primarily VBA adjudicative staff and lawyers. The information requested from you, the examiner, is based on adjudication needs and not on treatment considerations. In fact, the C&P examination is a forensic tool, used only to determine if a disability exists, or to document the degree to which a disability affects functions for the Veteran or Servicemember.

## Qualifications for Conducting TBI Examinations

### **Important!**

The initial medical diagnosis of TBI must be made by a physiatrist, psychiatrist, neurosurgeon, or neurologist.

It is important to note that the initial medical diagnosis of TBI must be made by a physiatrist, psychiatrist, neurosurgeon, or neurologist. A consultation to one of these specialty groups should be obtained if a TBI diagnosis made by one of these specialists, whether VHA, DOD or civilian is not already on record. If the examiner cannot determine the specialty of the provider who made the diagnosis, or if there is evidence in the record which may contradict the diagnosis, then a consultation to one of the above specialties should be made to confirm the diagnosis. Health care providers who may conduct C&P TBI examinations include physiatrists, psychiatrists, neurosurgeons, and neurologists, as well as generalist clinicians who have successfully completed the DEMO TBI training module for certification. C&P TBI certified clinicians are permitted to perform TBI residual disability examinations subject to existing VBA C&P guidance on examiner qualifications, including M21-1MR, III.iv.3.D.18.b.

Fast Letter 10-28:

**Health care providers who may conduct TBI examinations:**

Generalist clinicians, who successfully complete the Compensation and Pension Service (C&P) TBI training module, are permitted to perform TBI residual disability examinations, subject to existing VBA/C&P guidance on examiner qualification, including M21-1MR, III.iv.3.D.18.b.

Fast Letter 9-40:

**Health care providers who may conduct TBI examinations:**

Physicians who are specialists in Physiatry, Neurology, Neurosurgery, and Psychiatry and who have training and experience with Traumatic Brain Injury may conduct TBI examinations. The expectation is that the physician would have demonstrated expertise, regardless of specialty, through baseline training (residency) and/or subsequent training and demonstrated experience. In addition, a nurse practitioner, a clinical nurse specialist, or a physician assistant, if they are clinically privileged to perform activities required for C&P TBI examinations, and have evidence of expertise through training and demonstrated experience, may conduct TBI examinations under close supervision of a board-certified or board-eligible physiatrist, neurologist, or psychiatrist.

M21-1MR, III.iv.3.D.18.b:

VA medical facilities (or the medical examination contractor) are responsible for ensuring that examiners are adequately qualified.

Veterans Service Center (VSC) employees are *not* expected to routinely review the credentials of clinical personnel to determine the acceptability of their reports.

**Note:** The signature block of the examination report should contain the examiner's credentials.

## Purpose of the TBI Examination

A TBI is a historical event. Determination of TBI severity is important in the acute management and rehabilitation following the TBI. However, for disability evaluation purposes, initial severity does not determine long-term functional impairment.

No symptom is unique to TBI. Symptoms commonly seen after a TBI can also be seen in other disorders. There may be an overlap of manifestations of TBI residual conditions with symptoms of a comorbid mental, neurological, or other physical disorder that can be individually evaluated in a separate evaluation.

### Important Note

Depending on your discipline, you may not complete all examinations requested on the Examination Request. For example, a vision exam or mental disorder exam, if requested, would need to be performed by an appropriate specialist.

## How Extensive Are TBIs?

Statistics show TBI is an important public health problem. These numbers can help establish TBI prevention strategies, identify research and education priorities, and support the need for services among those living with a TBI. According to the Centers for Disease Control (2011), each year an estimated 1.7 million people in the United States sustain a TBI annually. Of them:

- 52,000 die,
- 275,000 are hospitalized, and
- 1.365 million, nearly 80%, are treated and released from an emergency department.

About 75% of TBIs that occur each year are concussions or other forms of mild (m)TBI. The number of people with TBI who are not seen in an emergency department or who receive no care is unknown. TBI is a common injury seen in military combat.

## What Criteria Defines a TBI?

A TBI occurs when any of the following happen after a traumatic event:

- Any loss of memory for events immediately before or after the injury (post-traumatic amnesia (PTA))
- Any alteration in mental state at the time of the injury (e.g., confusion, disorientation, slowed thinking)
- Neurological deficits (e.g., weakness, balance disturbance, praxis, paresis/plegia, change in vision, other sensory alterations, aphasia) that may or may not be transient
- Intracranial lesion

## TBI Severity Classification

The Veteran or Servicemember's TBI is classified as mild, moderate or severe based on meeting any criteria within the highest particular severity level. The severity classification is determined based on characteristics of the initial injury. However, for the purpose of the C&P examination, remember you are evaluating the individual's current functioning, not his/her functioning after the initial injury.

### TBI Severity Classification

MILD	MODERATE	SEVERE
<b>NORMAL STRUCTURE IMAGING</b>	<b>NORMAL OR ABNORMAL STRUCTURAL IMAGING</b>	<b>NORMAL OR ABNORMAL STRUCTURAL IMAGING</b>
AOC/LOC: 0 – 30 minutes	AOC/LOC: > 30 minutes, ≤ 24 hours	AOC/LOC: ≥ 24 hours
PTA: 0 – 1 day	PTA: > 1 day, ≤ 7 days	PTA: ≥ 7 days
Lowest GCS: 13 – 15 within the first 24 hours	Lowest GCS: 9 – 12 within the first 24 hours	Lowest GCS: 3 – 8 within the first 24 hours

LOC: Loss of Consciousness  
AOC: Alteration of Consciousness  
PTA: Post-traumatic amnesia  
GCS: Glasgow Coma Scale

There are three TBI severity classifications:

- A mild TBI (or mTBI) will have normal structural imaging. Alteration or loss of consciousness lasts from 0 to 30 minutes, and PTA from 0 to 1-day. Lowest Glasgow Coma scale in the first 24-hours will be between 13 and 15. More than 80% of all TBIs are mild in initial severity.
- Moderate TBI will have normal or abnormal structural imaging. Alteration of consciousness or loss of consciousness will be between 30 minutes and up to 24-hours, and PTA may last 1 day to 7 days. Lowest Glasgow Coma scale in the first 24-hours is between 9 and 12.
- Severe TBI may have normal or abnormal structural imaging. Loss or alteration of consciousness will be greater than 24-hours, and PTA greater than 7 days. Lowest Glasgow Coma Scale in the first 24hours will be between 3 and 8. If the individual has been in a "coma" at any time (i.e., GCS < 8), then they are considered to have sustained an initial severe TBI.

The Glasgow Coma Scale provides a score in the range 3-15. The total score is the sum of the scores in three categories. The Glasgow Coma Scale can be found in the Resources section of this course by selecting Resources at the bottom of this screen.

## Lesson Summary

Now, let's review what we have covered in this lesson on the C&P exam for TBI.

- We began by discussing the difference between a disability exam and a treatment exam. Remember, the C&P exam is conducted for legal purposes, not treatment purposes.
- We defined the purpose of the exam and the criteria for establishing a TBI. Keep in mind, a TBI is a historical event.
- We talked about who is qualified to be a C&P TBI examiner.
- We took a look at the TBI severity classifications, which are based on the characteristics of the initial injury, and learned that a TBI can be classified as mild, moderate, or severe based on meeting any criteria within the highest particular severity level.

Let's take a look at the best practices for activities you should perform prior to conducting a C&P TBI examination.

# Before the Examination

## Learning Objectives

The time allocated for a disability exam includes time for you to prepare for the examination. This lesson will cover best practices in preparing for a disability exam. The focus will be on thoroughly reviewing any documentation provided to you before the examination begins.

At the completion of this lesson, you will be able to describe best practices for activities performed prior to conducting a traumatic brain injury (TBI) compensation and pension (C&P) examination.

## Request for Examination (Form 2507)

When a Veteran or Servicemember files an original claim for compensation with the Department of Veterans Affairs (VA), a series of events is set in motion. Examinations are requested after the Veteran or Servicemember has made a substantially complete application for disability benefits and Veterans Benefits Administration (VBA) substantiates the validity of the claim. At a certain point in the process, an electronic exam request (Request for Examination, 2507) for a disability examination is initiated by the Regional Office (RO) and sent to the Veterans Health Administration (VHA) compensation and pension (C&P) clinic or to the equivalent Integrated Disability Evaluation System (IDES) clinic. For contractors, the request will come through Veterans Examination Request Information System (VERIS). Once scheduled, the examination request should be reviewed in detail by the examiner prior to conducting the requested examination. Here are the types of examination requests you might encounter while performing a TBI examination.

### Important Note:

The "General Remarks" section on the exam request form is essential and contains specific instructions. If the examiner has questions about any information on an exam request, he or she should call the RO for clarification before beginning the exam. This can avoid having the report returned by the (RO) with a request for additional information.

TYPES OF EXAMINATION REQUESTS	DEFINITION
<b>"Original Service-Connected" Exam</b>	The Veteran or Servicemember is claiming condition(s) he or she believes is (are) related to their military service. This is the first time the Veteran or Servicemember has applied for service connection of any disability or it is conducted in relation to a claim to reopen a previously denied claim for service connection. <b>History:</b> Take a detailed history of the claimed condition(s) on the Request for Examination from the origin of the condition(s) until today, including any mechanism of injury.
<b>"Claim for Increase" Exam</b>	The Veteran or Servicemember is already service-connected for a condition(s). The Veteran or Servicemember believes the condition(s) has (have) increased in severity since the last evaluation. <b>History:</b> Take a detailed history of the claimed condition(s) on the Request for Examination from the date of the last C&P examination until today, including where the Veteran goes for care of the condition(s). NOTE: It is not necessary to provide the history prior to the last C&P exam (such as the circumstances of the original onset of the disability) as this information has been previously documented.
<b>"Review" Exam</b>	The Veteran or Servicemember is already service-connected for a condition. VA is



TYPES OF EXAMINATION REQUESTS	DEFINITION
	<p>requesting an examination to see if the condition has changed since the last rating. (NOTE: For certain nonstatic disabilities, VA is required to periodically re-evaluate their disabling effects on the Veteran or Servicemember.) <b>History:</b> Take a detailed history of the claimed condition(s) on the Request for Examination from the date of the last C&amp;P examination until today, including where the Veteran or Servicemember goes for care of the condition(s). NOTE: It is not necessary to provide the history prior to the last C&amp;P exam (such as the circumstances of the original onset of the disability) as this information has been previously documented.</p>

## TBI Case Study

At this point, you will need to view the Request for Examination to determine what information you will need to provide to the Regional Office, including if you need to provide a medical opinion, the type of exams being requested, and the documentation protocols you will need to include in your examination report.

**Sample TBI – VA Form 21-2507 – Request for Examination  
(Patient, VHA One)**

**Name: Patient, VHA One**

**SSN: [put SSN here]**

**C-Number: 00 000 007**

**DOB: JULY 7, 1900**

**Address: 1 Street Ave**

**City, State, Zip+4: City, State 00000-0001**

**Country: UNITED STATES**

**Res Phone: (555) 555-1234**

**Bus Phone:**

**Entered active service: JUL 31, 2007**

**Released from active service: AUG 1, 2010**

>>>Future C&P Appointments<<<

No future C&P appointments found.

Requested exams currently on file:

INITIAL MENTAL DBQ

Requested on AUG 5, 2010@ 08:43:17 by INDIANAPOLIS-RO –Open

INITIAL PTSD DBQ

Requested on AUG 5, 2010@ 08:43:17 by INDIANAPOLIS-RO –Open

INITIAL TBI DBQ

Requested on AUG 5, 2010@ 08:43:17 by INDIANAPOLIS-RO –Open

This request was initiated on AUG 5, 2010 at 08:43:17

Requester: Provider, VHA One

Requesting Regional Office: INDIANAPOLIS-RO

VHA Division Processing Request: LOUISVILLE, KY VAMC

Exams on this request:

INITIAL MENTAL DBQ

INITIAL PTSD DBQ

INITIAL TBI DBQ

\*\* Status of this request:

**New**

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No rated disabilities on file

Other Disabilities:

General Remarks:

CLAIMS FILE BEING SENT FOR REVIEW BY THE EXAMINER.

Disabilities claimed:

1. depression
2. posttraumatic stress disorder
3. residuals of TBI due to IED blast: headaches

MILITARY SERVICE: Marine Corp 7/31/2007 to 08/01/2010

PERTINENT SERVICE TREATMENT RECORDS: No evidence of a mental disorder.

PERTINENT VA RECORDS: Vet meets the criteria for posttraumatic stress disorder (PTSD) and major depressive disorder with psychosis.

PRIVATE TREATMENT RECORDS: Social Security records show evidence of affective disorders and major depressive disorder.

The veteran is claiming service connection for Post Traumatic Stress Disorder (PTSD). We have conceded the in-service stressor of combat per the Training Letter 10-05 dated July 16, 2010.

Please examine in accordance with the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM IV, complete the PTSD DBQ, and provide his current level of disability. Please provide multi-axial evaluations (Axis I through V), as well as Global Assessment of Functioning (GAF), score based solely on veteran's PTSD and also comment on competency. If there is a post service intercurrent stressor, please identify and address its impact.

In addition, please conduct whatever additional testing is necessary based on your examination. In addition, please conduct whatever additional testing is necessary based on your examination and specifically state whether or not the claimed stressor is related to the Veteran's fear of hostile military or terrorist activity.

The examiner should specify the diagnosis for the psychiatric condition using the DSM-IV multi-axial format. All 5 axes should be addressed including Axis IV - severity of psychosocial stressors, and Axis V - global assessment of functioning (GAF). The GAF score should only include the symptomatology that is related to the service connected condition(s) and/or the condition(s) for which the veteran is claiming service connection. The GAF score should be discussed in terms of its consistency with the conclusions that are rendered regarding the extent of social and industrial adaptability. All necessary tests and studies should be conducted.

If PTSD is found along with other mental disorders, the severity of each psychiatric condition should be EVALUATED SEPARATELY to the greatest extent possible.

ALL OPINIONS expressed should be accompanied by a detailed rationale.

Thank you for your time and consideration.

POA: American Legion

We have the same address for this veteran as you.

If you have any questions, please contact Jane Doe, RVRS, at 317-555-5678.

## Review the C-file

Mr. Smith's Claims File (also known as the C-file) was sent with a Request for Examination since the file contains pertinent information for the disability exam. As an examiner, it is mandatory that you review the Veteran's C-file for TBI examinations. For IDES examinations, you are required to review the Servicemember's medical records. If the C-file or medical records are not sent with the Request for Examination, consult with your supervisor and follow your local facility's policy.

The C-file will allow you to gain an understanding of the status of the Veteran's or Servicemember's claim before the examination. The C-file contains private and sensitive information and includes important information, such as:

- Documentation of the claimed condition to date.
- How long has the claim been in process?
- Is there some other action such as a previous denial of the claim?
- Has the Veteran or Servicemember had mental health treatment outside of or within the VA system?
- Is there anything in the Veteran's or Servicemember's record that indicates mental health care during military service?
- Is there any supplemental paperwork that indicates how the Veteran or Servicemember may have presented symptoms in a previous exam? Are there findings or diagnoses from other clinicians?

### Side Note

Mr. Smith's C-file contains:

- Documentation of the claimed condition to date
- Military service history
- Entrance examination and physical examination report
- Treatments during military service
- Exit examination and physical examination report
- Previous C&P examination dates and reports
- Private medical information the Veteran or Servicemember submitted to the Regional Office

## Review the Appropriate Documentation Protocol

The TBI DBQ or other documentation protocol is used to guide the documentation of the examination, but is not necessarily used to guide the examination itself. You need to ensure you obtain the information that is required in order to fulfill the purpose and the needs of the examination and to complete an adequate report. The DBQ or other documentation protocol provides a uniform format for the examination report to obtain the necessary information for adjudication staff and lawyers. When you document a DBQ, you provide evidence necessary to adjudicate the Veteran's or Servicemember's claim.

As a practical matter, without the benefit of the DBQ or other documentation protocol, it would be possible to have a perfect examination from a medical perspective, but an insufficient examination report from an adjudicative perspective. The DBQ or other documentation protocol is in place to help ensure that the results of the examination are fully captured for consideration by the adjudicative staff. Remember, adjudicators decide claims based on the information in the DBQ or other documentation protocol as well as all other evidence of record.

For the purposes of this training, we will use the TBI DBQ, as noted in the Request for Examination. Remember, VBA needs specific, legally required information that is aligned with the Schedule for Rating Disabilities, often referred to as the Rating Schedule. The TBI DBQ can be located in the Resources section of this course by selecting Resources at the bottom of this screen.

**Review Evaluation of Residuals of Traumatic Brain Injury (R-TBI)  
Disability Benefits Questionnaire**

*\* Internal VA or DoD Use Only\**

Name of patient/Veteran: \_\_\_\_\_ SSN: \_\_\_\_\_

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.**

**VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.**

NOTE: Health care providers who may conduct traumatic brain injury (TBI) examinations include physiatrists, psychiatrists, neurosurgeons and neurologists, as well as generalist clinicians who have successfully completed the DEMO (CPEP) TBI training module. DEMO TBI-certified clinicians are permitted to perform TBI residual disability examinations subject to existing VBA guidance on examiner qualification, including M21-1MR, III.iv.3.D.18.b.

However, the diagnosis of TBI must be made by a physiatrist, psychiatrist, neurosurgeon or neurologist. A consultation to one of those specialty groups may need to be obtained in conjunction with this examination if the diagnosis is not already of record.

DEFINITION: Mild traumatic brain injury is defined as a traumatically-induced physiological disruption of brain function manifested by at least one of the following:

- Loss of consciousness  $\leq$  30 minutes
- Loss of memory for events immediately before (retrograde amnesia) or events after the accident (post-traumatic amnesia)  $\leq$  24 hours
- Any alteration in mental state at the time of the injury (dazed, disoriented, confused)
- Presence of focal neurological deficits
- If given, GCS score  $\geq$ 13

NOTE: In completing each Disability Benefits Questionnaire, clinicians should indicate the presence of only those findings, signs, symptoms, or residuals deemed attributable, in whole or in part, to the conditions in the Diagnosis Section. (For example, for a Stomach Questionnaire, indicate nausea is present only if the nausea is attributable to the stomach condition. If the Veteran has another cause for nausea, such as vertigo, do not indicate nausea. If needed, the clinician should provide additional clarification in the Remarks section.)

**SECTION I: Diagnosis and medical history**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a traumatic brain injury (TBI) or any residuals of a TBI?

Yes  No

If yes, select the Veteran's condition (check all that apply):

Traumatic brain injury (TBI) ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

Other diagnosed residuals attributable to TBI, specify:

Other diagnosis #1: \_\_\_\_\_

ICD code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Other diagnosis #2: \_\_\_\_\_

ICD code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Other diagnosis #3: \_\_\_\_\_

ICD code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

If there are additional diagnoses that pertain to the residuals of a TBI, list using above format: \_\_\_\_\_

## **2. Medical record review**

**Indicate medical records reviewed in preparation of this report:**

C-file (VA only)

Other, describe: \_\_\_\_\_

## **3. Medical history**

Describe the history (including onset and course) of the Veteran's TBI and residuals attributable to TBI (brief summary):  
\_\_\_\_\_

## **SECTION II: Assessment of facets of TBI-related cognitive impairment and subjective symptoms of TBI**

NOTE: For each of the following 10 facets of TBI-related cognitive impairment and subjective symptoms (facets 1-10 below), select the ONE answer that best represents the Veteran's current functional status.

Neuropsychological testing may need to be performed in order to be able to accurately complete this section. If neuropsychological testing has been performed and accurately reflects the Veteran's current functional status, repeat testing is not required.

### **1. Memory, attention, concentration, executive functions**

- No complaints of impairment of memory, attention, concentration, or executive functions
- A complaint of mild memory loss (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing
- Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment
- Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment
- Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment

If the Veteran has complaints of impairment of memory, attention, concentration or executive functions, describe (brief summary): \_\_\_\_\_

### **2. Judgment**

- Normal
- Mildly impaired judgment: For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision
- Moderately impaired judgment: For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions
- Moderately severely impaired judgment: For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision
- Severely impaired judgment: For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.

If the Veteran has impaired judgment, describe (brief summary):  
\_\_\_\_\_

### **3. Social interaction**

- Social interaction is routinely appropriate
- Social interaction is occasionally inappropriate
- Social interaction is frequently inappropriate
- Social interaction is inappropriate most or all of the time

If the Veteran's social interaction is not routinely appropriate, describe (brief summary):

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### **4. Orientation**

- Always oriented to person, time, place, and situation
- Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation
- Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation
- Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation
- Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation

If the Veteran is not always oriented to person, time, place, and situation, describe (brief summary):

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### **5. Motor activity (with intact motor and sensory system)**

- Motor activity normal
- Motor activity is normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function)
- Motor activity is mildly decreased or with moderate slowing due to apraxia
- Motor activity moderately decreased due to apraxia
- Motor activity severely decreased due to apraxia

If the Veteran has any abnormal motor activity, describe (brief summary):

---

### **6. Visual spatial orientation**

- Normal
- Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system)
- Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system)
- Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system)
- Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment

If the Veteran has impaired visual spatial orientation, describe (brief summary):

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## **7. Subjective symptoms**

- No subjective symptoms
- Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples are: mild or occasional headaches, mild anxiety
- Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light
- Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days

If the Veteran has subjective symptoms, describe (brief summary):

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## **8. Neurobehavioral effects**

NOTE: Examples of neurobehavioral effects of TBI include: irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.

- No neurobehavioral effects
- One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction.
- One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them
- One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them
- One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others

If the Veteran has any neurobehavioral effects, describe (brief summary):

---

## **9. Communication**

- Able to communicate by spoken and written language (expressive communication) and to comprehend spoken and written language.
- Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
- Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas
- Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs
- Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs

If the Veteran is not able to communicate by or comprehend spoken or written language, describe (brief summary):

---

## **10. Consciousness**

- Normal
- Persistent altered state of consciousness, such as vegetative state, minimally responsive state, coma.



If checked, describe altered state of consciousness (brief summary):

---

**SECTION III: Additional residuals, other findings, diagnostic testing, functional impact and remarks**

**1. Residuals**

Does the Veteran have any subjective symptoms or any mental, physical or neurological conditions or residuals attributable to a TBI (such as migraine headaches or Meniere's disease)?

Yes  No

If yes, check all that apply:

Motor dysfunction (other than those described in Section II.5)

If checked, ALSO complete specific Joint or Spine Questionnaire for the affected joint or spinal area.

Sensory dysfunction

If checked, ALSO complete appropriate Central nervous system, Cranial or Peripheral Nerve Questionnaire.

Hearing loss and/or tinnitus

If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.

Visual impairment

If checked, an Eye Questionnaire must ALSO be completed.

Alteration of sense of smell or taste

If checked, ALSO complete a Loss of Sense of Smell and Taste Questionnaire.

Seizures

If checked, ALSO complete a Seizure Disorder Questionnaire.

Gait, coordination, and balance

If checked, ALSO complete appropriate Questionnaire for underlying cause of gait and balance disturbance, such as Ear or Central nervous system Questionnaire.

Speech (including aphasia and dysarthria)

If checked, ALSO complete appropriate Questionnaire.

Neurogenic bladder

If checked, ALSO complete appropriate Genitourinary Questionnaire.

Neurogenic bowel

If checked, ALSO complete appropriate Intestines Questionnaire.

Cranial nerve dysfunction

If checked, ALSO complete a Cranial Nerves Questionnaire.

Skin disorders

If checked, ALSO complete a Skin and/or Scars Questionnaire.

Endocrine dysfunction

If checked, ALSO complete the appropriate endocrine Conditions Questionnaire.

Erectile dysfunction

If checked, ALSO complete Male Reproductive Conditions Questionnaire.

Headaches, including Migraine headaches  
If checked, ALSO complete a Headache Questionnaire.

Dizziness/Vertigo  
If checked, ALSO complete an Ear Conditions Questionnaire.

Mental disorder (including emotional, behavioral, or cognitive)  
If checked, Mental Disorders or PTSD Questionnaire must ALSO be completed.

Other, describe: \_\_\_\_\_  
If checked, ALSO complete appropriate Questionnaire.

**2. Other pertinent physical findings, scars, complications, conditions, signs and/or symptoms**

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_

**3. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran's current TBI residuals, repeat testing is not required. No specific imaging studies are indicated for evaluation of TBI.

a. Has neuropsychological testing been performed?

Yes  No

If yes, provide date: \_\_\_\_\_ Results: \_\_\_\_\_

b. Have diagnostic imaging studies or other diagnostic procedures been performed?

Yes  No

If yes, check all that apply:

Magnetic resonance imaging (MRI)  
Date: \_\_\_\_\_ Results: \_\_\_\_\_

Computed tomography (CT)  
Date: \_\_\_\_\_ Results: \_\_\_\_\_

EEG  
Date: \_\_\_\_\_ Results: \_\_\_\_\_

Other, describe: \_\_\_\_\_  
Date: \_\_\_\_\_ Results: \_\_\_\_\_

c. Has laboratory testing been performed?

Yes  No

If yes, specify tests: \_\_\_\_\_

Date: \_\_\_\_\_ Results: \_\_\_\_\_

d. Are there any other significant diagnostic test findings and/or results?

Yes  No

If yes, provide type of test or procedure, date and results (brief summary):

\_\_\_\_\_

#### **4. Functional impact**

Do any of the Veteran's residual conditions attributable to a traumatic brain injury impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran's residual conditions attributable to a traumatic brain injury, providing one or more examples: \_\_\_\_\_

#### **5. Remarks, if any:**

\_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician printed name: \_\_\_\_\_

Medical license #: \_\_\_\_\_

Physician address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**NOTE:** VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

## **Lesson Summary**

This lesson walked you through the process of preparing for a disability exam. Best practices call for a thorough review of all of the documentation provided to you.

- Your preparation began when you reviewed the Request for Examination.
- The next step in your preparation was to access the appropriate DBQ (or other documentation protocol) called for in the Request for Examination. Remember, the DBQ is designed to provide guidance to ensure that your exam report gives VBA all of the information—and just the information—needed.
- Finally, we reviewed the past service records and/or current medical records in the Veteran's or Servicemember's C-file, and medical records.

Mr. Smith has checked in on time for his disability exam. He is seated in the waiting room. The examiner is sitting at a desk in examination room reviewing the Request for Examination. He picks up the Veterans C-file and reviews the content. There is a knock at the door and Mr. and Mrs. Smith enter the examination room.

# During the Examination

## Learning Objectives

This lesson begins as you greet the Veteran or Servicemember. As a best practice, start guiding them through the disability exam when you introduce yourself. You will be providing the information specified on the Request for Examination and using the Disability Benefits Questionnaire (DBQ) or other documentation protocol to guide the documentation of your examination. This lesson also provides pointers on what you should or should not discuss with the Veteran or Servicemember as you close the disability exam. When you complete this lesson, you should be able to do all of the following:

- Apply best practices for opening, conducting, and closing a traumatic brain injury (TBI) compensation and pension (C&P) examination.
- Apply best practices for guiding the Veteran or Servicemember through the interview and examination process.
- Identify signs and symptoms of TBI sequelae.
- Explain when additional testing is indicated.

Now, let's get Mr. Smith's examination started.

## Greet the Veteran or Servicemember

When greeting the Veteran or Servicemember and conducting your initial interview, be sure to:

- Introduce yourself to the Veteran or Servicemember.
- Explain why the Veteran or Servicemember is there.
- Explain the focus of the exam.
- Discuss the difference between a disability and a treatment exam.
- Explain the purpose of the DBQ or other documentation protocol to the Veteran or Servicemember.
- Tell the Veteran or Servicemember to feel free to ask questions at any time during the examination.

It is critical before proceeding with the evaluation to determine if the Veteran or Servicemember is able to safely and adequately comprehend the purpose, nature, and scope of the evaluation. Ensure you evaluate the Veteran's or Servicemember's level of understanding and emotional ability to comprehend. If you determine the Veteran or Servicemember is unable to safely and adequately comprehend the purpose, nature, and scope of the evaluation, contact the RO or your supervisor. Read below to see how the examiner greets Mr. Smith and begins the pertinent history interview.

## Video Transcript

[The examiner reviews Mr. Smith's C-file.]

[The examiner gets up, opens door.]

DOCTOR: Mr. Smith?

MR. SMITH: Yes.

DOCTOR: Good morning I'm Doctor Riechers it's nice to meet you.

MR. SMITH: Nice to meet you. This is my wife Karen.

DOCTOR: Hi, nice to meet you.

KAREN: Hi nice to meet you.

DOCTOR: You both can come over here and have a seat in these chairs.

MR. SMITH: Okay.

[They sit down.]

DOCTOR: Mr. Smith you are here in our clinic today for a compensation and pension evaluation for a traumatic brain injury. The focus of this examination is going to be to review any injuries you may have experienced during your military service and discuss any long term effects of those injuries. The effects of those injuries will be used to determine compensation and disability healthcare benefits for your time here at the VA. The information will be gathered using this disability benefits questionnaire, so it's a structured way we gather the information. Uh, this examination will differ a little bit from a clinical examination in that the information we use won't be used for treatment purposes but rather for the purposes of establishing your disability.

MR. SMITH: Okay.

## Review Pertinent History

The examiner begins the examination by reviewing pertinent history with Mr. Smith. The examiner knows how important it is to take a detailed history that is appropriate for the type of exam requested on the Examination Request. For C&P Initial TBI examinations, sufficient information of the initial injury should be collected in order to document criteria to meet or not meet the diagnosis of TBI. Additional information on reviewing the Veteran's or Servicemember's pertinent history can be located in the Resources section of this course by selecting Resources at the bottom of this screen.

Requests for increase or review examinations only require an interval history; that is, from the date of the last C&P examination through the date of the current examination being conducted, assuming the listed points of history for each examination have previously been addressed and are service connected.

## Video Transcript

[Highlights of the History Interview]

DOCTOR: I reviewed your C-file, but I want to review some of the information with you to confirm its accuracy. So you're how old?

MR. SMITH: 25.

DOCTOR: And are you a lefty or a righty?

MR. SMITH: I'm a lefty.  
DOCTOR: Okay. And you were in which branch of the service?  
MR. SMITH: I was in the Marine Corps.  
DOCTOR: And during your time in service did you have any deployments?  
MR. SMITH: Yes. Twice. Well I was active in 2007, deployed in 2008, and I was deployed again in 2010.  
DOCTOR: Okay. During either of those deployments, did you suffer any injuries?  
MR. SMITH: Yes. In 2010, I was in uh, two explosions.  
DOCTOR: Tell me about the first explosion.  
MR. SMITH: Uh, the first one was an IED. Um, uh on the side of our Humvee, it was me and two other marines. Um, uh we were unconscious for a little bit, then we were up and fighting right afterwards.  
DOCTOR: Did you have any problems or symptoms after you came to from being unconscious?  
MR. SMITH: Immediately after? No, like I said we were in a fight for about thirty minutes right afterwards. So no, we were up and fighting.  
DOCTOR: And you were able to function and do everything you need to do without difficulty then?  
MR. SMITH: Yeah, we won.  
DOCTOR: Okay. Any headaches or any problems in the rest of the day, after that injury?  
MR. SMITH: No. I mean I was on adrenaline for that first thirty minutes.  
So no, I was fine.  
DOCTOR: And no subsequent symptoms in the days that followed that injury?  
MR. SMITH: No, I don't think so.  
DOCTOR: Tell me about your second injury.  
MR. SMITH: Second one was about a month later. That was a grenade that exploded about five feet in front of me, sent me flying back. I got a little bit of shrapnel in my hand, and my arm, and my hip. Um, uh and I was unconscious for a couple minutes. Then when I woke up, took me to the hospital and put me back under again.  
DOCTOR: Okay. So after you woke up from surgery, what problems were you noticing or experiencing?  
MR. SMITH: Headaches. My head hurt. Especially right when I woke up, it hurt pretty bad um, uh most of the day. It started to subside a little bit, then I was getting them about twice a day. I still get them about twice a day.  
DOCTOR: Okay.  
[The interview continues.]  
DOCTOR: So it sounds like the more severe headaches do impact your function. How about the milder headaches, do they limit you or impair you from doing things with your family or work, etc?  
MR. SMITH: They're a pain, but I continue on with the day, yeah.  
DOCTOR: How long do each of these headaches last?  
MR. SMITH: The lighter ones, 30 minutes to 45 minutes. The heavy ones, about an hour.  
DOCTOR: And have you taken anything for any of the headaches?  
MR. SMITH: Ibuprofen.  
[The interview ends.]  
DOCTOR: The next part of the evaluation is going to move on to the physical examination.  
MR. SMITH: Okay.

## Case Study

You just watched as the examiner validated the information he reviewed in the Veteran's C-file.

Mr. Smith is a 25-year-old who was in the Marine Corps for three and a half years. He was most recently deployed to Afghanistan from August through December of 2010. He reports that at the end of November, he was the passenger in a Humvee that was hit by an improvised explosive device on the driver side. He was with two other Marines at the time and reports that all three of them experienced a loss of consciousness for less than one minute. There was some mild confusion at the time of regaining consciousness, but they acted very quickly and subsequently participated in a firefight, which lasted approximately 30 minutes. Mr. Smith was wearing a helmet and had no significant residual deficits thereafter.

He was in a second explosion approximately one month later. Mr. Smith was on foot patrol when a grenade exploded less than five feet away from him. He was thrown backwards by the impact of the blast; he had a loss of consciousness for approximately two minutes. He was evacuated from theater and treated emergently for injuries to his hand, hip, and forearm. Mr. Smith immediately underwent orthopedic surgery and does not recall any subsequent events until waking up after his surgery.

Mr. Smith reported ongoing symptoms, including almost daily headaches ranging from seven to nine out of ten in severity. He reported severe hearing difficulty, as well as significant difficulty in falling asleep and staying asleep. He also reported having nightmares every night. He reported severe irritability and being easily annoyed. His current medications included Seroquel, which he felt was improving his irritability and helping him sleep. Mr. Smith reported that his symptoms were getting worse since he returned home. On physical examination, he was alert and cooperative. His neurologic examination was essentially normal. His physical examination was consistent with the injuries to his hand, forearm, and hip. Neuropsychological testing was ordered as a part of the examination as there were no formal cognitive or behavioral assessments available in the C-file.

### **3. Medical history**

Describe the history (including onset and course) of the Veteran's TBI and residuals attributable to TBI (brief summary): 25-year -old Veteran with two minute LOC following blast exposure December 2010 during OEF deployment. He also sustained soft tissue injuries to his hand, forearm, and hip. He has been experiencing near daily headaches following this trauma and complains of impaired memory and concentration that was noted only after his return from deployment. He has impaired sleep and experiences frequent nightmares. He was diagnosed with PTSD in 2011. He also reports significant hearing difficulty following exposure to several blasts during his deployment.

#### **Important Note:**

Remember, you cannot complete your report until you have incorporated the results from all testing.

## **Conduct the Physical Examination**

Now that the examiner has taken a detailed history that is appropriate for the type of exam being requested, he is ready to begin the physical examination. He keeps in mind that approximately 90% of the physical examination relates to the TBI history. It is now the examiner's responsibility to determine if Mr. Smith has any subjective symptoms or any objective findings of mental, physical, or neurological conditions or residual attributes involving any of the following key physical examination elements:

- Motor dysfunction
- Sensory dysfunction
- Hearing loss and/or tinnitus
- Visual impairments
- Alteration of sense of smell or taste
- Seizures
- Gait, coordination, and balance
- Speech (including aphasia and dysarthria)
- Neurogenic bladder
- Neurogenic bowel
- Cranial nerve dysfunction
- Skin disorders
- Endocrine dysfunction

### **Important Note:**

It is important to determine if all reported symptoms began proximate to the injury, specifically within the first two weeks, as this is more indicative of a causal relationship. Remember the Veteran or Servicemember may not be able to provide this information due to memory deficits. In such a case, you may want to use a collateral source.

## **Differential Diagnosis – Distinguishing Symptoms**

Unfortunately, there is no one symptom that is unique to, or diagnostic of mTBI. Most of these symptoms occur in normal healthy individuals and may overlap. So the question becomes, is this history, examination, and group of symptoms, consistent with TBI, or is it more likely something else? In those individuals reporting long-term postconcussive symptoms following mTBI, their clinical presentation may be very similar to related disorders, including PTSD or major depression. For instance, individuals may report sleep difficulties, memory problems, irritability, and anxiety that fit any of these diagnoses. Within the context of a C&P evaluation, you may be asked to determine if symptoms are attributable to TBI or to other diagnoses (specifically, examiners are often asked to distinguish whether symptoms are attributable to a mental health disorder). Mittenberg and Strauman (2000) suggest the following considerations in differential diagnosis:

### **Postconcussive Syndrome versus Post-Traumatic Stress Disorder.**

Postconcussive syndrome (PCS) is not associated with persistent re-experiencing of the accident or numbing of general responsiveness, whereas PTSD is. In contrast, PTSD is not characterized by dizziness, generalized memory problems, headaches, or subjective intellectual impairment, while PCS is.

### **Postconcussive Syndrome versus Major Depression.**

Postconcussive syndrome is not associated with changes in appetite or weight, psychomotor agitation or retardation, suicidal ideation, or a history of depressive disorder. In general, differential diagnosis may be a challenge when evaluating a patient with mTBI. For additional information on TBI please refer to the 2010 Veterans Health Initiative Traumatic Brain Injury Independent Study Course. The URL for this course is located in the Resources section at the bottom of this page.

## **Residuals**

After determining that the Veteran or Servicemember has had an event that may have resulted in a TBI, you should specifically address the history of each symptom, or residual, as described in the DBQ or other documentation protocol. Since individuals with TBI may have difficulty organizing and communicating their symptoms without prompting, it is important to ask about and document all problems, whether subtle or pronounced, so that the Veteran or Servicemember can be appropriately evaluated for all disabilities associated with TBI. You must address each one of the signs or symptoms and report the findings in as much detail as necessary. Negative as well as positive responses to residual symptoms should be documented. Ask what types of treatments have been used and whether they have been effective.

## **Motor Dysfunction**

Now watch as the examiner performs reflex testing. He uses the criteria for reflex testing.

### **Criteria for Reflex Testing:**



- Test for biceps, brachioradialis, triceps reflexes in upper extremities
- Test for knee and ankle jerks in lower extremities
- Grading
  - 4+ – clonus present
  - 3+ – brisker than normal, without clonus
  - 2+ – normal
  - 1+ – trace response
  - 0 – no reflex
- Test for Babinski response, if feet are very sensitive, try Chaddock (stroking outer side of foot)

When assessing motor dysfunction, you should ask about the frequency, severity, and duration of motor dysfunction and the impact on daily functioning. If the Veteran or Servicemember complains of weakness, mobility problems or paralysis, describe the symptoms and locations. Ask what types of treatments have been used and if they have been effective. To the extent possible, identify the specific peripheral nerves that innervate the weakened or paralyzed muscles. Describe any muscle atrophy or loss of muscle tone. To view a typical Grading of Muscle Strength Chart, refer to the Resources section located at the bottom of this page.

Examine and report deep tendon reflexes and any pathological reflexes. Motor dysfunction findings and symptoms are not typically seen with mTBI. For all of the residuals reviewed in the course, you may need to complete additional documentation, if the residual symptoms are endorsed.

#### **Important Note:**

All DBQs must be completed prior to submitting your report. This applies to all conditions that may be involved.

#### **Video Transcript**

[Highlights of the Motor Function Assessment]

DOCTOR: The next part of the examination is going to be to evaluate your motor function, or your strength and muscles.

MR. SMITH: Okay.

DOCTOR: We're gonna start in the arms and then move to the legs. The first muscles I'd like to test are the deltoid muscles.

[The assessment continues.]

DOCTOR: The next thing I'd like for you to do is to hold your hands out in front of you, like you're holding a pizza. Put them out as straight as you can and as far as you can. And then I want you to close your eyes. Okay, you can relax and open your eyes. Now we're gonna move on to the legs. The first thing I wanna test is the strength of the flexion of your leg. So I want you to hold onto the table.

MR. SMITH: Alright.

DOCTOR: And first bring your right leg up, off the table as far as you can. And push up. Does that cause you a little bit of pain?

MR. SMITH: Little bit.

DOCTOR: Okay now let's try on the left.

[The assessment continues.]

DOCTOR: The next part of your exam is gonna be testing your reflexes.

MR. SMITH: Okay.

DOCTOR: So let me have you relax your arms in your lap. I'm gonna tap on your reflexes. You just relax. Here on the forearm, on the left and the right. And at the biceps, on the left and on the right. Then the triceps, on the left and on the right. And we're gonna move down into the legs.

MR. SMITH: Okay.

DOCTOR: I'm gonna tap you here at the knee, on the left and again on the right. And then here behind the ankle, on the right and the left. Okay. The next reflex we're going to test is something called the Babinski sign. I'm going to tickle the bottom of your foot with this piece of wood. It might be a little uncomfortable, but I won't hurt you try not to pull away for me. Okay?

MR. SMITH: Mm-hm.

DOCTOR: Start on the right foot and then on the left. Very good.

## Sensory Dysfunction

As a best practice, the examiner should ask about the frequency, severity, and duration of any sensory dysfunction and the impact on daily functioning. If the Veteran or Servicemember complains of sensory changes, such as numbness or paresthesias, describe the location and type. If the Veteran or Servicemember complains of hypersensitivity to sound or light, describe. Note that a complete sensory examination of all modalities can take a significant amount of time. Assess with basic sensory screening of extremities then focus on areas where the Veteran or Servicemember has complaints. If the Veteran or Servicemember has no complaints of sensory changes, a basic sensory assessment is still recommended.

### Basic Sensory Screen

For basic sensory screening use the following technique:

- Test sharp/dull, light touch and proprioception or vibration in hands and feet
- Test for extinction on double simultaneous testing – hand and face on opposite sides of the body, ipsilateral hands, ipsilateral face, ipsilateral hand and face. Abnormal is mislocalization of any touch.

## Autonomic Nervous System Dysfunction

Sensory changes are not typically seen with mTBI. If the Veteran or Servicemember complains of symptoms of autonomic nervous system dysfunction, describe any complaint such as hyperhidrosis, heat intolerance, orthostatic, or postural hypotension. If orthostatic hypotension is present, report whether or not it is associated with dizziness or syncope on standing. Ask what types of treatments have been used and whether they have been effective.

## Hearing Loss and/or Tinnitus

You should ask about the frequency, severity, and duration of their hearing loss and/or tinnitus and the impact on daily functioning. If the Veteran or Servicemember complains of hearing problems, such as decreased hearing or tinnitus, describe. If findings are positive, the Veteran or Servicemember will need to be scheduled for an audiology exam with a C&P certified audiology specialist. Ask what types of treatments have been used and about their effectiveness.

# Aspects of Sensory Screening

## Visual Impairment

If the Veteran or Servicemember complains of visual disturbances, describe. Ask about the frequency, severity, duration and any treatment of visual impairment and the impact on daily functioning. Perform a screening exam for vision. If any abnormalities are found, or if there are symptoms or complaints of visual impairment, request an eye exam by a C&P certified eye specialist. In mTBI, visual disturbances are rarely caused by difficulty with visual pathways, and are more likely due to problems with executive functioning. Remember, the Veteran's or Servicemember's eye exam must be completed before your examination report can be submitted.

## Sense of Smell or Taste Impairment

The examiner should ask about the frequency, severity, and duration of their altered sense of smell or taste and the impact on daily functioning. If the Veteran or Servicemember reports a decreased sense of taste or smell, describe. The olfactory nerve is the most commonly injured nerve in mTBI; however, this is still a rare finding in mTBI. Impaired sense of smell is often manifested as a loss of taste, rather than a complaint of loss of the sense of smell. Veterans or Servicemembers may lose weight due to their loss of sense of taste and smell. Check for functional loss of cranial nerve 1 in any Veteran or Servicemember who reports loss of sense of taste or smell. Ask what types of treatments have been used and whether they have been effective.

## Seizures

Seizures are extremely rare sequelae of mTBI, occurring in less than 0.5% of cases, but are seen more frequently after moderate, severe, or penetrating injuries. Ask about the type, frequency, severity, and duration of seizures and the impact on daily functioning. Ask what types of treatments have been used and whether they have been effective.

## Gait, Coordination, and Balance

Read as the examiner evaluates Mr. Smith's gait, coordination, and balance.

Generally speaking, if the Veteran or Servicemember is ambulatory, describe what devices, if any, are needed to assist in walking. When describing the Veteran's or Servicemember's gait, a tandem assessment is recommended. Describe objective findings abnormality, imbalance, incoordination, or spasticity. Assess any limitation of gait that is caused by joint rigidity or spasticity of muscle movements. Ask what types of treatments have been used and if they have been effective. Balance and ambulatory problems are rarely seen with mTBI, unless dizziness is present.

The Dix-Hallpike test (also called the Nylen-Barany test) is a diagnostic maneuver used to identify benign paroxysmal positional vertigo (BPPV), a common balance disorder. If positive, complete the Cranial Nerve DBQ or other documentation protocol. To view the steps of the Dix-Hallpike Maneuver, refer to the Resources section located at the bottom of this page.

## Video Transcript

[Highlights of the Gait, Coordination, and Balance Assessment]

DOCTOR: The next thing we're gonna test is your coordination.

MR. SMITH: Okay.

DOCTOR: First thing we're gonna do is evaluate the arms. So what I'd like for you to do is to take your right index finger.

MR. SMITH: Okay.

DOCTOR: Touch the tip of your nose.

[Doctor extends finger in front of him.]

MR. SMITH: Now take that same index finger and move to touch my finger. And you are going to go back and forth between the two. Excellent. Now with the left arm do the same thing. Very good. Now we're gonna test your ability to do rapid movements.

MR. SMITH: Okay.

DOCTOR: So what I want you to do is tap the palm of your right hand and then the back of your hand, back and forth. Fast as you can. Now with your left hand. Very good. And the last thing I'd like to do is watch you walk. So if you could step down.

MR. SMITH: Okay.

DOCTOR: And I'd like you to walk to the door and back with your arms at your side, your normal walk.

MR. SMITH: Alright.

[Toward the door]

DOCTOR: And then come back to me. And then I would like you to take some steps on your tip toes.

[Toward the door]

DOCTOR: And then when you come back I would like you to walk on your heels. And finally, I would like you to walk to the door like you're walking on a tight rope, one foot in front of the other, heel touching toe. Excellent. You can walk back to the bed normally, and turn around. Keep standing and face me. The last thing I wanna do is evaluate your balance.

MR. SMITH: Okay.

DOCTOR: So I'd like to have you take- put your feet together. Put your arms out to the side. And I want you to close your eyes.

[Palms down]

DOCTOR: Keep your balance. Okay, you can open your eyes and relax your arms.

## Speech (including Aphasia and Dysarthria)

Ask the Veteran or Servicemember if they have any speech or swallowing difficulties. Swallowing problems of any type or overt speech difficulties are extremely rare after mTBI. Identify the following information:

- Severity and specific type of problem
- Primary language (aphasia)
- Difficulty with articulation because of injuries to mouth
- Aspiration due to difficulty swallowing, etc.
- Frequency, severity, and duration of symptoms and the impact on daily functioning

Ask what types of treatments have been used and whether they have been effective. These findings and symptoms are not typically seen with mTBI.

## Neurogenic Bowel and Bladder

Ask about the frequency, severity, and duration of any neurogenic bladder or bowel dysfunction and the impact on daily functioning. These difficulties are never a primary result of an mTBI and are highly unlikely as a long term sequelae of moderate TBI, but can occur in severe TBI. Report type of bladder impairment such as incontinence, urgency, urinary retention, etc., and measures needed such as catheterization or pads. Also report the type and frequency of need to evacuate bowels, and any assistance needed such as digital stimulation, suppositories, etc. Ask what types of treatments have been used and if they have been effective.

## Cranial Nerve Screening

### Cranial Nerve Dysfunction

Read as the examiner performs a cranial nerve screening on Mr. Smith.

The examiner asks about the frequency, severity, and duration of any symptom associated with cranial nerve dysfunction and the impact on daily functioning. To view the elements of a cranial nerve screening, refer to the Resources section located at the bottom of this page.

If cranial nerve screening is positive, ask what types of treatments have been used and whether they have been effective. If identified, complete a Cranial Nerves Questionnaire or other documentation protocol.

### Video Transcript

[Highlights of the Cranial Nerve Assessment]

DOCTOR: Alright Mr. Smith. The next part of the examination is going to be a physical evaluation of your neurologic system. I'm gonna check you over from head to toe. I'm gonna ask you to do several different things, just try to do your best that you can. And I'll guide you along the way. The first thing we're gonna do is evaluate your cranial nerves. And we're gonna start with the valuation of the sense of smell. For this test, I am going to present you with different odors. You are going to have your eyes closed and cover one nostril. And just identify for me what it is that you smell. Okay?

MR. SMITH: Okay.

DOCTOR: So first let me have you cover your right nostril. And close your eyes. And breathe in.

[Holds bottle up to nose.]

DOCTOR: And what do you smell?

MR. SMITH: Uh, mint.

DOCTOR: Very good, you can open your eyes. Go ahead and cover your left nostril. And now tell me what you smell?

[Holds bottle up to nose]

MR. SMITH: Coffee.

DOCTOR: Very good. You can open your eyes. Okay, next thing we're gonna test is your vision. And the first part of your vision we're gonna test is the peripheral vision. So I want you to look at the tip of my nose. I'm going to show you a number of fingers on my hands. I want you to tell me how many fingers you see. And if I show you more than one, I want you to add them up for me.

MR. SMITH: Okay.

DOCTOR: Now.

[Extends fingers]

MR. SMITH: Three. One. Four. Three. Two. Five.

DOCTOR: Very good. The next thing we're going to test is the back of your eyes. I'm gonna take a look in the back of your eyes with some bright light. So I apologize if it's uncomfortable. During this evaluation, I want you to just pick a spot on the wall opposite you and keep staring at that spot even if I get in the way. Okay?

MR. SMITH: Okay.

[The assessment continues]

DOCTOR: Next we're gonna move on to checking some of the other functions of the cranial nerves. We're gonna check the sensation in your face. Okay?

MR. SMITH: Okay.

DOCTOR: To check that sensation, I'm gonna use this stick. There's gonna be a sharp side and a dull side.

MR. SMITH: Okay.

DOCTOR: I want you to close your eyes and just tell me sharp or dull.

MR. SMITH: Alright.

[Doctor breaks a Q-tip]

DOCTOR: Okay, we're about to begin. So, here.

[Doctor will touch face]

MR. SMITH: Sharp. Dull. Sharp. Sharp. Dull. Dull.

DOCTOR: Very good. You can open your eyes.

MR. SMITH: Okay.

DOCTOR: I wanna check the movements in your face. First thing I want you to do is open your eyes very wide. Now I want you to close your eyes, as tight as you can. Now you can relax. And I want you to smile and show me your teeth. And you can relax. The next thing I'm gonna test is your hearing. To do that I'm gonna move my fingers on the left or the right behind your ears.

MR. SMITH: Okay.

DOCTOR: I want you to just identify left or right as to which side you hear the sound coming from.

MR. SMITH: Okay.

MR. SMITH: Left. Right. Both.

DOCTOR: Very good. Next I want to evaluate the movement of your mouth and tongue.

MR. SMITH: Okay.

DOCTOR: Now I want you to open your mouth as wide as you can, and say ahhh.

MR. SMITH: Ahhh.

DOCTOR: Now stick your tongue out for me. Very good. You can relax.

## **Skin Disorders and Endocrine Dysfunction**

Ask about the frequency, severity, and duration of any skin disorders and the impact on daily functioning. Conduct a screening exam and describe any areas of skin breakdown due to neurological problems. Ask what types of treatments have been used and if they have been effective.

Endocrine dysfunction findings and symptoms are extremely rare with mTBI. If present, ask about the frequency, severity, and duration of symptoms related to endocrine disorders and the impact on daily

functioning. Conduct a thorough screening and describe any findings consistent with endocrine problems. Ask what types of treatments have been used and whether they have been effective.

## **Sexual Dysfunction**

Sexual dysfunction is not a typical physiologic finding after mTBI. If the Veteran or Servicemember complains of erectile dysfunction or other types of sexual dysfunction, ask questions in a sensitive manner. Ask what types of treatments have been used and whether they have been effective. If identified, the examiner should also complete the appropriate questionnaire or other documentation protocol.

## Headaches, Including Migraine Headaches

Ask about the frequency, severity, and duration of headaches and the type; migraine-like, tension-type, or cluster headaches (rare) and the impact on daily functioning. Note that headaches may be of mixed character and there may be cervicogenic, neck-related pain.

For Veterans or Servicemembers presenting with persistent headache, knowing the mechanism of injury can help identify the cause, such as acceleration or deceleration injury as in whiplash or direct impact injury. Determine what types of treatments have been used and if they have been effective. It is important to document if the Veteran or Servicemember had headaches prior to the injury and what the course of symptoms have been since the trauma occurred.

## Mental Disorder-Including Emotional, Behavioral or Cognitive

If the Veteran or Servicemember complains of psychiatric symptoms such as mood swings, anxiety, depression, etc., a C&P certified mental health examiner should work in conjunction with the TBI examiner. Note: if the TBI examiner is a psychiatrist, the psychiatrist can complete both the TBI and mental health evaluations. While new psychiatric symptoms and diagnoses can be seen after TBI, other than depression, it is rare. Neurobehavioral symptoms are common in moderate and severe TBI, but can present similarly to psychiatric disorders. In mTBI, symptoms can also occur, but are typically less severe in nature and may indicate untreated anxiety, depression, or post-traumatic stress disorder symptoms.

Keep in mind that behavioral changes may be due to general anxiety disorder, PTSD, or non-restorative sleep or pain disorders. The most common behavioral symptoms seen in the first several weeks after mTBI include irritability and difficulty with interpersonal relationships, such as with spouse, children, or co-workers. These symptoms are typically first manifested in the 2 to 4 weeks post-injury, if causally related. As the Veteran or Servicemember was likely not around his/her family after injury, you should also ask about relationships with other Servicemembers. With treatment of these disorders, the neurobehavioral symptoms in mTBI will typically improve, but can persist if undertreated or can re-emerge if new life stressors occur.

## Suicide Risk in Veterans and Service Members

### Suicide Risk in Veterans and Servicemembers

Based on information available from the Centers for Disease Control and VA, Veterans and Servicemembers die by suicide at a higher rate than the general population. As an examiner, it is important to note that Veterans or Servicemembers undergoing any transitions, including the compensation and pension exam process, may be at higher risk for suicide.

Suicidal thoughts and behaviors are commonly found at increased rates among individuals with psychiatric disorders, especially major depressive disorder, bipolar disorders, schizophrenia, PTSD, anxiety, chemical dependency, and personality disorders. A history of a suicide attempt is the strongest predictor of future suicide attempts, as well as death by suicide. Intentional self-harm (i.e., intentional self-injury without the expressed intent to die) is also associated with long-term risk for repeated attempts as well as death by suicide. Additionally, the risk of suicide may increase with the severity of Veterans' and Servicemembers' war-related injuries.

All Veterans and Servicemembers who present with a history of a mental health diagnosis or with any of the suicide warning signs and risk factors should have a further suicide risk assessment which can be completed either by the examiner or by referral, secondary to the C&P examination process. In the event the Veteran's or Servicemember's screening or behavior is positive for danger to him or herself or others, an emergent evaluation should be performed.

To access helpful documents to have on hand and to view the Suicide Prevention Resources for Providers website refer to the Resources section located at the bottom of this page.

### **Important Note:**

All Veterans and Servicemembers, regardless of risk, should be given the Veterans Crisis Line number. A Veteran or Servicemember can reach the Veterans Crisis Line by dialing: 1-800-273-TALK (8255), and then pressing 1.

## **Memory Disorders**

If the Veteran or Servicemember complains of memory impairment, describe whether the memory impairment is mild, moderate, or severe. Difficulties with attention and concentration are most common and often lead to difficulties with short-term memory. Problems with long-term memory, especially memory of events before the injury, are not common with mTBI, and often suggest an alternative pathology.

### **Assessment of Cognitive Impairment/Other Residuals of TBI**

General assessment of cognitive impairment and other residuals of TBI include the evaluation of:

1. Consciousness
2. Communication
3. Orientation
4. Memory, attention, concentration, executive functions
5. Judgment
6. Social interaction
7. Neurobehavioral effects
8. Motor activity (with intact motor and sensory systems)
9. Visual spatial orientation
10. Subjective symptoms

## **Cognitive Problems**

### **Cognitive Problems**

Describe other cognitive problems that the Veteran or Servicemember demonstrates. Reports of difficulty with attention, concentration, and memory should always be followed up with brief objective testing such



as a Mini-Mental Exam (MME) or Montreal Cognitive Assessment (MOCA). Read as the examiner performs a MOCA test on Mr. Smith. To review a sample of the Montreal Cognitive Assessment (MOCA), refer to the Resources section located at the bottom of this page.

Screening evaluations are helpful for ruling out cognitive disorders. However if found, these tests are not specific as to the cause of cognitive disorders such as TBI, depression, anxiety, sleep disorder, pain disorder, or other functional deficit. Comprehensive neuropsychological testing, specific to TBI, is often needed to clarify the degree and type of cognitive (and behavioral) deficits. The examiner should request any testing he or she deems necessary, based on the types of symptoms and deficits the Veteran or Servicemember is experiencing. Positive cognitive screening may require referral to the appropriate C&P certified mental health examiner. If you are unsure as to which tests to requests, contact your supervisor.

If neuropsychological testing has been performed and accurately reflects the Veteran's or Servicemember's current functional status, repeat testing is not required. Remember that any required testing must be completed prior to submitting your report.

**Note:**

Cognitive problems may include any of the following problems:

- Slowness of thought
- Confusion
- Decreased attention
- Difficulty concentrating
- Difficulty understanding directions
- Difficulty using written language or comprehending written words
- Delayed reaction time
- Difficulty with executive functions (such as speed of information processing, alternating attention, goal setting, planning, organizing, prioritizing, self-monitoring, problem-solving, judgment, decision making, spontaneity, or flexibility and changing actions when they are not productive)

**Video Transcript**

[Highlights of the Memory and Concentration Assessment]

DOCTOR: The next part of the evaluation is going to be a physical examination. And the first part of that physical examination is going to be an evaluation of your cognitive function, including memory and attention. I'm going to ask you a whole bunch of questions, some of them may seem very basic and some of them may seem difficult. I just want you to try your best, okay?

MR. SMITH: Okay.

DOCTOR: The first part of the evaluation is actually going to be done on this piece of paper and it involves some writing. Do you see here on the left the letters and numbers?

MR. SMITH: Yeah.

DOCTOR: And do you see how they've begun to connect the dots using the pattern: number, letter, number?

MR. SMITH: Okay.  
DOCTOR: Can you finish connecting the rest of the dots for me using that pattern?  
MR. SMITH: Yes.  
[The assessment continues.]  
DOCTOR: Now I'm going to read you a list of words. I want you to listen to all those words and repeat them back to me.  
MR. SMITH: Okay.  
DOCTOR: Truck, banana, violin, desk, green.  
MR. SMITH: Violin, truck, banana, desk, green.  
DOCTOR: Very good. I'm going to read them to you one more time.  
MR. SMITH: Okay.  
DOCTOR: Listen to them all. Repeat them back to me. Truck, banana, violin, desk, green.  
MR. SMITH: Uh, truck, banana, violin, desk, green.  
DOCTOR: Very good. I want you to hold onto those words in your memory because I'm going to ask you for them in a few minutes.  
MR. SMITH: Okay.  
[The assessment continues.]  
DOCTOR: What's 90 minus 7?  
MR. SMITH: It's uh, 83.  
DOCTOR: And how about 7 from that?  
MR. SMITH: 76.  
DOCTOR: Okay. And 7 from that?  
MR. SMITH: 69.  
DOCTOR: And 7 from that?  
MR. SMITH: 62.  
DOCTOR: And 7 from that?  
MR. SMITH: 55.  
DOCTOR: Very good. Now I am going to read you a couple of sentences. I want you to listen to each sentence and repeat it back to me.  
MR. SMITH: Okay.  
DOCTOR: The first sentence is: A bird can fly into closed windows when it's dark and windy.  
MR. SMITH: A bird can fly into closed windows when it's windy.  
DOCTOR: The next sentence is: The caring grandmother sent groceries over a week ago.  
MR. SMITH: The caring grandmother sent groceries a week ago.  
DOCTOR: Okay.  
[The assessment continues.]  
DOCTOR: Next I'm going to tell you two words. The two words have something in common. I want you to identify for me what it is they have in common.  
MR. SMITH: Okay.  
DOCTOR: For example, if I said carrot and potato, you would say?  
MR. SMITH: Vegetable.  
DOCTOR: What about diamond and ruby?  
MR. SMITH: Uh, rock.  
DOCTOR: What about cannon and rifle?  
MR. SMITH: Gun.  
DOCTOR: Very good. And what were those five words I wanted you to hold onto?  
MR. SMITH: Um, violin, banana, truck, green.  
DOCTOR: There was one more. Do you remember what that was?  
MR. SMITH: Desk.  
DOCTOR: Okay, very good. Can you tell me the date today?  
MR. SMITH: It is October 25, 2011.  
DOCTOR: And what day of the week is it?  
MR. SMITH: It's Tuesday.

## **Sleep Disturbance**

If the Veteran or Servicemember complains of sleep disturbance, describe the type and frequency. Also describe any complaints of fatigue. Sleep disturbance and fatigue are very common complaints in the general population and in a variety of conditions, including post-traumatic stress disorder (PTSD), anxiety, and depression.

When related to mTBI, these issues almost always resolve with time, unless another disorder is present. Observe the Veteran or Servicemember for any psychiatric manifestations, including neurobehavioral effects.

## **Other Conditions**

Ask the Veteran or Servicemember if they have any other problem areas or symptoms. If they complain of any other symptoms, describe those symptoms. If additional symptoms are identified, complete the appropriate questionnaire or other documentation protocol.

## **Residuals**

Complete the associated DBQ or other documentation protocol for any residuals identified.

## **Potential Additional TBI Documentation**

The table shown here matches each residual with additional DBQs or other documentation protocols that may be required to complete your TBI examination. In addition to these potential DBQs, you may also need to consult with providers who are certified to complete the additional DBQs.

### Potential Additional TBI Documentation

RESIDUAL SYMPTOMS	ADDITIONAL POTENTIAL DOCUMENTATION THAT MAY BE REQUIRED
Motor Dysfunction	Six major joint DBQs to include: Shoulder, Elbow, Wrist, Hip, Knee and Ankle, as well as Hand and Foot, Cervical Spine, and Thoracolumbar Spine DBQs
Sensory Dysfunction	Cranial Nerves, Peripheral Nerves, Hearing loss and Tinnitus, Eyes, <b>and</b> Loss of Sense of Smell and Taste
Autonomic Nervous System Dysfunction	Cranial nerve DBQ: peripheral nerve DBQ or other appropriate documentation
Hearing Loss and/or Tinnitus	Hearing DBQ: AUDIO Hearing Loss and Tinnitus. C&P certified Audiologist required.
Visual Impairment	Visual DBQ: OPTO Eyes. C&P certified Ophthalmologist or Optometrist required
Sense of Smell or Taste Impairment	Loss of Sense of Smell and Taste DBQ or other appropriate documentation
Seizures	Seizure Disorder DBQ or other appropriate documentation
Gait, Coordination, and Balance	Ear (gait and coordination disturbances) DBQ or other appropriate documentation
Speech (including Aphasia and Dysarthria)	Complete the appropriate questionnaire or other documentation protocol
Neurogenic Bladder and Bowel	Genitourinary DBQ, Intestines DBQ or other documentation protocol
Cranial Nerve Dysfunction	Central Nervous System and Neuromuscular Diseases DBQs or other documentation protocol
Skin Disorders	Skin and/or Scars DBQ or other documentation protocol
Endocrine Dysfunction	Endocrine Conditions DBQ or other documentation protocol
Sexual Dysfunction	Male Reproductive Conditions DBQ or other documentation protocol
Headaches, including Migraine Headaches	Headache DBQ or other documentation protocol
Mental Disorder - Including Emotional, Behavioral or Cognitive	Mental Disorders DBQ, PTSD DBQ or other documentation protocol
Other Conditions	Other appropriate documentation

## Functional Impact

The TBI DBQ specifically addresses functional impact. Determining the functional impairment a disability has on the Veteran's or Servicemember's lifestyle is an essential aspect of C&P examinations. Even though this section is short you are asked to describe the impact of each of the Veteran's or Servicemember's residual conditions attributable to a traumatic brain injury, providing one or more examples. This section requires careful consideration.

Examples will come from activities of daily living and routine daily activities. Activities of daily living refer to activities such as basic self-care, and include showering, dressing, eating, getting in and out of bed or a chair, and using the toilet. Routine daily activities refer to activities such as:

- Care of others (including selecting and supervising caregivers)
- Care of pets
- Child rearing
- Communication management
- Community mobility

- Financial management
- Health management and maintenance
- Home establishment and management
- Meal preparation and cleanup
- Religious observance
- Safety and emergency maintenance
- Shopping

It is particularly important to describe any effects for each symptom present and provide information on the impact the symptom has on the Veteran's or Servicemember's routine daily activities or employment. There is not a place on the DBQ to address each of these items, as the purpose of the DBQ is to document the examination process. If additional room is needed, discuss these symptoms in Remarks.

## Close the Disability Examination

Read as the examiner closes the examination. He will ask Mr. Smith if he has any questions.

Generally speaking, you should provide clear instructions on what happens next. As an examiner, you are responsible for the way people feel after your conversation with them. Consider that in many instances, the appointment with you is the first contact the Veteran or Servicemember has with the VA. If you are courteous and appear interested, the Veteran or Servicemember will likely leave with the impression that you are concerned about his or her situation. Escort the Veteran or Servicemember to the door or direct to the way out.

If the Veteran or Servicemember asks about the outcome of their claim, explain that this is not a decision that the clinician makes. Inform the Veteran or Servicemember that your role is to perform the examination for VBA. Explain that VBA will determine the final rating, and will mail the results to him or her. Do not respond by speculating on a claim outcome.

### Topics to Avoid

You should avoid discussing or addressing any of these issues during or while closing a disability exam:

- The merits of the claim
- Percentage of service-connected disability to be granted
- Likely outcome or benefits as a result of examination
- Your opinion regarding relationship of the disability to service, unless a specific question concerning those issues has been asked by the Regional Office
- Correctness of a determination that a disability is or is not service-connected
- Treatment recommendations

## Video Transcript

[Examiner completes exam report.]

DOCTOR: Well Mr. Smith I've gathered enough information for my portion of the compensation and pension evaluation. I'll complete your disability benefits questionnaire. There are a couple areas we need to expand on, so I am going to refer you to two other specialists. One of them is an audiologist, which is a hearing specialist; the other is a vision specialist. They'll both do examinations to help us in this process as well. Do you have any questions at this time?

MR. SMITH: Yeah. um what did I qualify for?

DOCTOR: So, at this point, I am not involved in the decision about your qualification. I simply gather the information from today. The Veterans Benefit Administration will make a final decision about your rating and qualification.

MR. SMITH: Okay.

KAREN: Okay, so in the meantime what are some things that we can do to minimize his symptoms?

DOCTOR: What I would recommend for evaluation and treatment of your symptoms that you go to see your primary care physician. And if you haven't engaged in the VA clinical system for medical care, I would recommend you do that as soon as possible, so you can start treating some of these symptoms you're experiencing.

MR. SMITH: Okay. Um, when are we gonna hear by?

DOCTOR: So it takes some time for this rating to be completed, it may be a matter of weeks to months until you hear via the mail from the Veterans Benefits Administration.

MR. SMITH: Okay.

DOCTOR: Okay, do you have any further questions?

KAREN: Not at this time.

MR. SMITH: No.

DOCTOR: If not, you're free to go. It was very nice to meet you.

MR. SMITH: Nice to meet you.

KAREN: Nice to meet you.

DOCTOR: Nice to meet you, ma'am.

## Lesson Summary

Let's review what we learned in this lesson on conducting the C&P TBI examination.

- We started by discussing the importance of taking a detailed history that is appropriate for the requested exam type. Because TBI is primarily a historical diagnosis, it's extremely important that you gather pertinent historical, personal, and medical information about the Veteran or Servicemember.
- We then moved on to look at the DBQ or other documentation protocol and how to complete it when taking the Veteran's or Servicemember's medical history.
- We then walked you through the physical exam findings that are particularly important to the ratings specialists who make the disability determinations. Remember, it is important to determine if the reported symptoms began proximate to the injury, specifically within the first two weeks, as this is more indicative of a causal relationship.
- Next, we discussed the importance of describing any effects for each symptom identified and to provide information on the impact the symptom has on the Veteran's or Servicemember's routine daily activities and/or employment.
- We concluded this lesson by emphasizing the importance of providing clear instructions to the Veteran or Servicemember on what's next without speculating on legal opinions.

Now that you have completed your TBI examination, let's review best practices for using the DBQ or other documentation protocol to document the C&P examination.

# Document the Examination

## Learning Objectives

As an examiner, it is your role to ensure you complete your documentation based on Veterans Benefits Administration (VBA) needs. Your report findings should be documented during and immediately after the examination of the Veteran or Servicemember using appropriate fields on the disability benefits questionnaire (DBQ), or other documentation protocol. At the end of this lesson, you will be able to:

- Incorporate the interpretation of any diagnostic tests into the compensation and pension (C&P) report.
- Apply best practices for using a disability benefits questionnaire (DBQ) or other documentation protocol to document a traumatic brain injury (TBI) compensation and pension (C&P) examination.

## Complete Each DBQ or Other Documentation Protocol

Review and interpret your diagnostic findings, including any ordered tests, and make a diagnostic conclusion relevant to the claim. Answer all questions in the Remarks section of the Request for Examination. Refer to the DBQ or other documentation protocol often during the exam to ensure you include all the important history and exam findings required to substantiate diagnoses for all claimed conditions. Describe current signs and symptoms, and include any functional limitations imposed by the TBI residuals. You should also report any current treatment and any side effects. If, during the examination, an emergency situation arises, whether physical or mental, take the appropriate steps to mitigate the situation immediately.

### Diagnostic Do's

Here are a few things you should do regarding your diagnosis:

- Provide a specific diagnosis: Provide a specific diagnosis rather than using phrases such as "differential diagnosis" or "rule out."
- Symptoms or signs: Provide an exact diagnosis if known instead of using symptoms (pain) or signs (tenderness).
- When ordering further studies, evaluations, or laboratory tests: If further studies, evaluations or tests are necessary, perform them before making a final decision. Otherwise the examination is incomplete and will be returned as insufficient. You should not give an opinion prior to performing and evaluating further required tests.
- Keep the previously established service connected diagnoses: Keep previously established diagnoses, unless you carefully explain the discrepancy and adequately substantiate a new diagnosis.

## Order and Arrange Diagnostics and Clinical Tests

Although a thorough physical examination and history are the initial elements of a post-mTBI clinical workup, a variety of other tests and tools are available to TBI examiners to clarify examination findings. Remember that tests such as neuroimaging, electrophysiological testing and computerized posturography only need to be considered by the C&P certified physiatrist, neurologist or neurosurgeon when a previous diagnosis of TBI is not documented.

# Neuropsychological Evaluations

## False Positives

An accurate TBI evaluation needs to discern between actual TBI residuals or other comorbid conditions. False positives may occur and should be recognized. Neuropsychological testing may provide a solution to this need.

A false positive would be a Veteran or Servicemember that does not have a mTBI, or at least does not have lingering pure cognitive effects from a mTBI, but the effects appear as a pre-morbid history of difficulties in the areas being evaluated and may appear as if affected by the mTBI. For instance; attention problems, learning disabilities, poor sleep or chronic pain. The examiner might find poor performance in someone that really doesn't have deficits the way the scores portray them on the test. Neuropsychological tests are typically very good at identifying level of effort. If low effort is suspected, false positives can be sorted out with further neuropsychological evaluation.

If neuropsychological testing has been performed and accurately reflects the Veteran's or Servicemember's current functional status, repeat testing is not required. Neuropsychological evaluations assess cognitive and psychological functioning but do not determine whether a brain injury occurred.

Unlike moderate to severe TBI, which typically is self-evident due to abnormalities on neuroimaging, e.g., MRI, and initial prolonged loss of consciousness, the diagnosis of mTBI often may be based solely on self-report. In those cases, eliciting a detailed history of the Veteran's or Servicemember's experience of the injury may help determine if there was an alteration or loss of consciousness and hence, an mTBI, resulting in residuals.

## Making the Diagnostic Conclusion

List each diagnosis. It is important that you state the diagnoses precisely. If you cannot provide a precise diagnosis, you must provide justification for the lack of diagnosis. You must also provide a comment on its association with a claimed TBI. For example, for the Veteran's or Servicemember's claimed condition of headaches, the diagnosis is, "TBI-associated tension headache. This condition is at least as likely as not to have been caused by, or a result of, the Veteran's or Servicemember's claimed TBI, as the onset of the condition occurred immediately following the blast injury."

## Case Study

The examiner referred Mr. Smith to a C&P certified neuropsychologist for testing. During Mr. Smith's neuropsychological testing, he reported mild depression and anxiety. Additionally, the Veteran was above average on tests of attention, processing speed, and verbal memory. Mr. Smith's visual memory was on the lower side of the average range, and overall cognitive functioning appeared to be in the normal range.

Based on the results of history and examination, the examiner concluded that Mr. Smith suffered a mild TBI (mTBI) during deployment and that his baseline headaches, having started shortly after his surgery, were related to the mTBI. However, Mr. Smith also had other symptoms that were most likely not related to his TBI, and these may have included the worsening of his headaches, irritability, his sleep disturbance, and nightmares. If it is impossible to make such a determination without speculation, the mental health examiner should say so and provide a rationale for why it is impossible. The examiner reviewed all reports before completing his evaluation. To see how the DBQ was documented by the examiner, refer to the Resources section located at the bottom of this page.



## Describe Capacity to Manage Financial Affairs

You must include the capacity to manage financial affairs in your exam report. Mental competency, for VA benefits purposes, refers only to the ability of the Veteran or Servicemember to manage VA benefit payments in his or her own best interest, and not to any other subject. Mental incompetency, for VA benefits purposes, means that the Veteran or Servicemember, because of injury (or disease), is not capable of managing benefits in his or her best interest. In order to assist raters in making a legal determination as to competency, you should address the following factors:

- What is the impact of injury or disease on the Veteran's or Servicemember's ability to manage his or her financial affairs? Consideration of such things as knowing the amount of his or her VA benefit payment, knowing the amounts and types of bills he or she owes monthly, and handling the payment prudently should be considered. Does the Veteran or Servicemember handle the money and pay the bills himself or herself?
- Based on your examination, do you believe that the Veteran or Servicemember is capable of managing his or her financial affairs? Provide examples to support your conclusion.

## Document Requested Opinion

An opinion should be given only when the Request for Examination requests it. Do not provide a documented or verbal opinion regarding the merits of any claim or the percentage evaluation that should be assigned for a disability. Remember, an opinion should not be discussed with the Veteran or Servicemember regarding these considerations:

- Insurability
- Degree of disability
- Incurrence or aggravation by military service
- Character and sufficiency of treatment during or subsequent to military service

### Important Note:

Be sure to review the form carefully to provide all requested information. If a medical opinion is requested for a claim, you should:

- Identify the specific evidence reviewed and considered in forming the opinion
- Provide a rationale (explanation/basis) for the opinion presented
- State the opinion in the legally acceptable format

## Remarks and Opinions—Mental Disorders

When a mental disorder is present, be sure you communicate with the C&P certified mental health examiner so they can state, in as much detail as possible, which emotional or behavioral signs and symptoms are part of the comorbid mental disorder which represents residuals of TBI. If it is impossible to make such a determination without speculation, the mental health examiner should say so. If a mental health exam is requested by either the examiner or RO, the examiner must coordinate his or her response with the mental health provider. If the examiner is a psychiatrist, he/she can comment without consultation.

## Lesson Summary

Now, let's review what we have covered in this lesson on the documenting the C&P examination.

- We learned what you do after the examination is completed and what should be included in your written report, including the findings from all additional clinical tests ordered, and your judgment of the Veteran's or Servicemember's capacity to handle financial affairs.
- You were then provided with an overview of diagnostic testing. It was here we pointed out that a thorough history and physical examination are the initial elements of a post-mTBI evaluation, but a variety of other tools are available to you to clarify examination findings.
- Remember, tests such as neuroimaging, electrophysiological testing, and computerized posturography can only be ordered by a C&P certified physiatrist, neurologist or neurosurgeon when a previous diagnosis of TBI is not documented.
- Next, we touched on the importance of stating your diagnoses precisely.
- We concluded this lesson by discussing medical opinions and that an opinion should only be given when the Request for Examination requests it.

Remember, if you cannot provide a precise diagnosis, you must provide justification for not providing it.

## Summary of Course

Let's review what you have covered in this program on the C&P exam for TBI. We began by providing a definition of TBI. Then, we talked about reviewing the Veteran's or Servicemember's C-file and medical history in preparation for conducting the exam, before the Veteran or Servicemember arrives. Remember that you should pay special attention to whether or not a diagnosis of TBI is included in the Veteran's or Servicemember's medical records. TBI is not the ratable entity but a historical diagnosis. The ratable entities are the residual effects. You should diagnose the residual disabilities in relation to TBI as the causal factor.

We then moved on to look at the DBQ or other documentation protocols and how to complete them when taking the Veteran's or Servicemember's medical history. We walked you through the physical exam findings that are particularly important to the ratings specialists who make the disability determinations.

We covered what you have to do after the exam is finished and what you should include in your written report, including the findings from all additional clinical tests ordered, and your judgment of the Veteran's or Servicemember's capacity to handle financial affairs.

### **Important Note:**

VBA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's or Servicemember's application.

## Resources

### Documents

Review Evaluation of Residuals of Traumatic Brain Injury (R-TBI), Disability Benefits Questionnaire (see Appendix)  
M21-1MR, III.iv.3.D.18.b (see Appendix)  
Conditions Following Trauma that Meet TBI (see Appendix)  
Cranial Nerve Exam (see Appendix)  
Dix Hallpick Maneuver (see Appendix)  
Glasgow Coma Scale (see Appendix)  
Grading of Muscle Strength (see Appendix)  
Reviewing Veteran History (see Appendix)  
TBI Severity Chart (see Appendix)  
Sample Opinion (see Appendix)  
Request for Examination (see Appendix)

## Appendix

Review Evaluation of Residuals of Traumatic Brain Injury (R-TBI), Disability Benefits Questionnaire  
M21-1MR, III.iv.3.D.18.b  
Conditions Following Trauma that Meet TBI  
Cranial Nerve Exam  
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Fast Letter 10-28:

**Health care providers who may conduct TBI examinations:**

Generalist clinicians, who successfully complete the Compensation and Pension Service (C&P) TBI training module, are permitted to perform TBI residual disability examinations, subject to existing VBA/C&P guidance on examiner qualification, including M21-1MR, III.iv.3.D.18.b.

Fast Letter 9-40:

**Health care providers who may conduct TBI examinations:**

Physicians who are specialists in Physiatry, Neurology, Neurosurgery, and Psychiatry and who have training and experience with Traumatic Brain Injury may conduct TBI examinations. The expectation is that the physician would have demonstrated expertise, regardless of specialty, through baseline training (residency) and/or subsequent training and demonstrated experience. In addition, a nurse practitioner, a clinical nurse specialist, or a physician assistant, if they are clinically privileged to perform activities required for C&P TBI examinations, and have evidence of expertise through training and demonstrated experience, may conduct TBI examinations under close supervision of a board-certified or board-eligible physiatrist, neurologist, or psychiatrist.

M21-1MR, III.iv.3.D.18.b:

VA medical facilities (or the medical examination contractor) are responsible for ensuring that examiners are adequately qualified.

Veterans Service Center (VSC) employees are *not* expected to routinely review the credentials of clinical personnel to determine the acceptability of their reports.

**Note:** The signature block of the examination report should contain the examiner's credentials.

## Conditions Following Trauma That Meet the Definition of TBI

Four conditions following trauma that meet the definition of TBI are listed here:

1. Any loss of memory for events immediately before or after the injury (post-traumatic amnesia PTA)
2. Any alteration in mental state at the time of the injury (e.g., confusion, disorientation, slowed thinking);
3. Neurological deficits (e.g., weakness, balance disturbance, praxis, paresis/plegia, change in vision, other sensory alterations, aphasia.) that may or may not be transient;
4. Intracranial lesion

## Cranial Nerve Examination

- I – test olfaction –\*\* (reported to be most often injured in mTBI)
- II – test visual acuity, fundoscopic examination, confrontational visual fields\*\*
- III, IV, VI – test pupillary size and reactivity, test range of extraocular motion, test saccades \*\*
- V – test facial sensation to light touch and pin, test symmetry of jaw movements/opening (rarely reported in mTBI)
- VII – test symmetry of facial movements (reported to be one of the most often injured in mTBI)
- VIII – screen hearing symmetry – finger rub\*\* (also reported to be one of the most often injured in mTBI) Vestibular – if there are positional symptoms perform the Hallpike-Dix maneuver
- IX-X – assess palatal movement, gag
- XI – assess SCM mass and contraction
- XII – assess tongue protrusion

\*\* indicates higher yield for TBI assessment

## Dix-Hallpike Maneuver

Here is a description of the Dix-Hallpike Maneuver and information regarding what the patient's reaction to the test suggest.

- Inform the patient that the procedure may provoke dizziness
  - keep the patient seated upright
  - the patient's head is turned 30 to 45 degrees to the side being tested
  - keep the patient eyes focused on your eyes
  - patient's head held and made to lie supine within about two seconds so that the neck lies hyperextended about 20 degrees past the horizontal plane
  - eyes are observed for torsional nystagmus for up to 30 seconds
- Interpretations of the test
  - horizontal nystagmus after a two- to 20-second latent period suggests a peripheral vestibular cause such as injury to the vestibule
  - vertical nystagmus or nystagmus without a latent period suggests a central vestibular cause such as brainstem injury

## GLASGOW COMA SCALE

### Eye Opening Response

Eye Opening Response	Value
Spontaneous--open with blinking at baseline	4 points
Opens to verbal command, speech, or shout	3 points
Opens to pain, not applied to face	2 points
None	1 point

### Verbal Response

Verbal Response	Value
Oriented	5 points
Confused conversation, but able to answer questions	4 points
Inappropriate responses, words discernible	3 points
Incomprehensible speech	2 points
None	1 point

### Motor Response

Motor Response	Value
Obeys commands for movement	6 points
Purposeful movement to painful stimulus	5 points
Withdraws from pain	4 points
Abnormal (spastic) flexion, decorticate posture	3 points
Extensor (rigid) response, decerebrate posture	2 points
None	1 point

### Grading of Muscle Strength

**0 = Absent**- No muscle movement felt.

**1 = Trace**- Muscle can be felt to tighten, but no movement produced.

**2 = Poor**- Muscle movement produced only with gravity eliminated.

**3 = Fair** - Muscle movement produced against gravity, but cannot overcome any resistance.

**4 = Good**- Muscle movement produced against some resistance, but not against "normal" resistance.

**5 = Normal** - Muscle movement can overcome "normal" resistance

**Note:** "Give-away" weakness as an indication of poor effort

## Reviewing Veteran or Servicemember’s Pertinent History

The first question you should ask the Veteran or Servicemember is the date and nature of the TBI. Elicit a statement from the Veteran or Servicemember confirming that the TBI occurred during military service, even if it is already documented in the C-file.

You should also keep the following considerations and requirements in mind:

- Recall the four conditions following trauma that meet the definition of TBI and that the diagnosis is based on historical factors. Document all these factors as applicable.
- Identify when the Veteran’s or Servicemember’s current symptoms started in relationship to the TBI, and if/how the symptoms have progressed. (e.g., “Do you have a headache? When did that start, and what has the course of the headaches been until now?”)
- State severity rating of the TBI at the time of injury.

## TBI Severity Chart

Mild	Moderate	Severe
Normal structure imaging	Normal or abnormal structural imaging	Normal or abnormal structural imaging
AOC/LOC: 0 – 30 minutes	AOC/LOC: > 30 minutes, ≤ 24 hours	AOC/LOC: ≥ 24 hours
PTA: 0 – 1 day	PTA: > 1 day, ≤ 7 days	PTA: ≥ 7 days
Lowest GCS: 13 – 15 within the first 24 hours	Lowest GCS: 9 – 12 within the first 24 hours	Lowest GCS: 3 – 8 within the first 24 hours

## Acronyms

LOC – Loss of consciousness

AOC – Alteration of Consciousness

PTA – Post-traumatic amnesia

CGS – Glasgow Coma Scale

## Sample Opinion

Name of patient/Veteran: \_\_\_\_\_ SSN: \_\_\_\_\_

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.**

NOTE: Health care providers who may conduct traumatic brain injury (TBI) examinations include physiatrists, psychiatrists, neurosurgeons and neurologists, as well as generalist clinicians who have successfully completed the DEMO (CPEP) TBI training module. DEMO TBI-certified clinicians are permitted to perform TBI residual disability examinations subject to existing VBA guidance on examiner qualification, including M21-1MR, III.iv.3.D.18.b.

However, the diagnosis of TBI must be made by a physiatrist, psychiatrist, neurosurgeon or neurologist. A consultation to one of those specialty groups may need to be obtained in conjunction with this examination if the diagnosis is not already of record.

DEFINITION: Mild traumatic brain injury is defined as a traumatically-induced physiological disruption of brain function manifested by at least one of the following:

- Loss of consciousness  $\leq$  30 minutes
- Loss of memory for events immediately before (retrograde amnesia) or events after the accident (post-traumatic amnesia)  $\leq$  24 hours
- Any alteration in mental state at the time of the injury (dazed, disoriented, confused)
- Presence of focal neurological deficits
- If given, GCS score  $\geq$ 13



**Sample TBI – VA Form 21-2507 – Request for Examination  
(Patient, VHA One)**

**Name: Patient, VHA One**

**SSN: [put SSN here]**

**C-Number: 00 000 007**

**DOB: JULY 7, 1900**

**Address: 1 Street Ave**

**City, State, Zip+4: City, State 00000-0001**

**Country: UNITED STATES**

**Res Phone: (555) 555-1234**

**Bus Phone:**

**Entered active service: JUL 31, 2007**

**Released from active service: AUG 1, 2010**

>>>Future C&P Appointments<<<

No future C&P appointments found.

Requested exams currently on file:

INITIAL MENTAL DBQ

Requested on AUG 5, 2010@ 08:43:17 by INDIANAPOLIS-RO –Open

INITIAL PTSD DBQ

Requested on AUG 5, 2010@ 08:43:17 by INDIANAPOLIS-RO –Open

INITIAL TBI DBQ

Requested on AUG 5, 2010@ 08:43:17 by INDIANAPOLIS-RO –Open

This request was initiated on AUG 5, 2010 at 08:43:17

Requester: Provider, VHA One

Requesting Regional Office: INDIANAPOLIS-RO

VHA Division Processing Request: LOUISVILLE, KY VAMC

Exams on this request:

INITIAL MENTAL DBQ

INITIAL PTSD DBQ

INITIAL TBI DBQ

\*\* Status of this request:

**New**

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No rated disabilities on file

Other Disabilities:

General Remarks:

CLAIMS FILE BEING SENT FOR REVIEW BY THE EXAMINER.

Disabilities claimed:

1. depression
2. posttraumatic stress disorder
3. residuals of TBI due to IED blast: headaches

MILITARY SERVICE: Marine Corp      7/31/2007    to    08/01/2010

PERTINENT SERVICE TREATMENT RECORDS: No evidence of a mental disorder.

PERTINENT VA RECORDS: Vet meets the criteria for posttraumatic stress disorder (PTSD) and major depressive disorder with psychosis.

PRIVATE TREATMENT RECORDS: Social Security records show evidence of affective disorders and major depressive disorder.

The veteran is claiming service connection for Post Traumatic Stress Disorder (PTSD). We have conceded the in-service stressor of combat per the Training Letter 10-05 dated July 16, 2010.

Please examine in accordance with the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM IV, complete the PTSD DBQ, and provide his current level of disability. Please provide multi-axial evaluations (Axis I through V), as well as Global Assessment of Functioning (GAF), score based solely on veteran's PTSD and also comment on competency. If there is a post service intercurrent stressor, please identify and address its impact.

In addition, please conduct whatever additional testing is necessary based on your examination. In addition, please conduct whatever additional testing is necessary based on your examination and specifically state whether or not the claimed stressor is related to the Veteran's fear of hostile military or terrorist activity.

The examiner should specify the diagnosis for the psychiatric condition using the DSM-IV multi-axial format. All 5 axes should be addressed including Axis IV - severity of psychosocial stressors, and Axis V - global assessment of functioning (GAF). The GAF score should only include the symptomatology that is related to the service connected condition(s) and/or the condition(s) for which the veteran is claiming service connection. The GAF score should be discussed in terms of its consistency with the conclusions that are rendered regarding the extent of social and industrial adaptability. All necessary tests and studies should be conducted.

If PTSD is found along with other mental disorders, the severity of each psychiatric condition should be EVALUATED SEPARATELY to the greatest extent possible.

ALL OPINIONS expressed should be accompanied by a detailed rationale.

Thank you for your time and consideration.

POA: American Legion

We have the same address for this veteran as you.

If you have any questions, please contact Jane Doe, RVRS, at 317-555-5678.

# Glossary

## B

### BVA

Board of Veterans' Appeals

## C

### C-file

Claims File, the folder that contains the Veteran's, Servicemember's, or Veteran's or Servicemember's STRs, claim correspondence, evidence including medical records, and documentation of all benefit awards. The Claims File is confidential and the Veteran may not have access to this claims file without the presence of an authorized VBA representative. Claims files should not be given to Veterans to carry from one clinic to another or from the Medical Center to the Veterans Service Center.

### Combat Service

Claims related to combat services have significant differences, mostly on the evidentiary burden on the Veteran or Servicemember. For claims based on combat service, satisfactory lay or other evidence that an injury or disease was incurred or aggravated in combat will be accepted as sufficient proof of service connection if the evidence is consistent with the circumstances, conditions or hardships of such service even though there is no official record of such incurrence or aggravation.

## CPRS

Computerized Patient Record System, VA's electronic health record system

## D

### Direct Service Connection

For disability resulting from personal injury suffered or disease contracted in line of duty, in the active military, naval, or air service, compensation will be paid to any Veteran discharged or released under conditions other than dishonorable from the period of service in which such injury or disease was incurred. In other words, direct service connection is established if the Veteran's or Servicemember's current disability was caused by or resulted from his military service. When all of the evidence, including that pertinent to service, establishes that a condition was incurred in service, direct service connection can still be established even though there was no documented complaint or symptoms of the condition in service.

## DBQ

Disability Benefits Questionnaire, a form designed to solicit pertinent and easily accessible medical information from treatment records to support a claim for benefits. DBQs are concise,

straightforward documentation tools tailored to the VA Schedule for Rating Disabilities (Rating Schedule). A DBQ is more a forensic than clinical medical report. DBQs enable VA to access resources of the private medical community and streamline the disability examination process.

## **DEMO**

Disability Examination Management Office, functions as a national oversight program established primarily to monitor VHA C&P performance and disability examination-related issues within VA. DEMO collaborates closely with other governmental programs and offices, such as the Veterans Benefits Administration (VBA) and the Department of Defense Integrated Disability Evaluation Program (IDES).

## **I**

### **Increase Exam**

An Increase exam involves an evaluation of a disability that has already been determined as SC. The Veteran believes the claimed condition(s) has worsened since the last rating examination. You should take a detailed history of the condition(s) identified in the examination request from the date of the last C&P examination until today.

### **Inadequate Exam**

An Inadequate exam is requested when a prior exam report is deemed insufficient for adjudication purposes. Examples of an inadequate exam request include, but are not limited to, these oversights: the report is unsigned; the report does not address all disabilities for which an examination was requested; exam template, worksheet, or DBQ is not fully completed; or a medical opinion was requested but not provided; or a medical opinion was provided but it either does not include a supporting rationale or the rationale provided is incomplete or otherwise inadequate.

## **L**

### **Lay Evidence**

Lay evidence is defined as any evidence or statements by a person without specialized education, training, or experience. In other words, this is a statement provided by someone who does not have a medical background or training, i.e. not a clinician. Generally, this evidence is provided by a person who has the knowledge of facts or circumstances and conveys matters that can be observed through the senses or via firsthand knowledge.

## **M**

### **Montreal Cognitive Assessment (MOCA) Test**

The MOCA Test is designed to assess abilities that may be impaired with TBIs, such as executive function and processing speed. These are abilities that are not assessed in other tests such as the mini-mental exam, another popular screening instrument.

## N

### **Neuropsychological Testing**

The neuropsychological testing takes approximately 2-5 hours and evaluates the areas of: intellectual functioning, attention, concentration, problem-solving, judgment, memory, learning, language, visual cognitive abilities, flexibility of thought, speed of information processing, psychological adjustment, and personality.

### **Nonservice-connected (NSC) disability**

A disability or disabilities resulting from a disease or injury that was not incurred or aggravated in active military service

### **Nonservice-Connected (NSC) Disability Pension**

A needs-based monetary benefit for wartime Veterans who are permanently and totally disabled from NSC disability or a combination of SC and NSC disabilities, not the result of their own willful misconduct.

## O

### **Original SC Examination**

An original claim to establish SC disability involves a Veteran or Servicemember who claims for the first time a condition or conditions that he or she believes is related to an injury, illness, or event that occurred during military service. When you conduct the examination, you should take a detailed history of the claimed condition or conditions from the date of onset until the present day, including any mechanism of injury. Make sure you report any diagnosis, symptoms, functional limits, and/or treatment the Veteran or Servicemember received before, during, and after military service.

### **Original NSC Pension Examination**

An evaluation of a disability resulting from a disease or injury that was not incurred or aggravated in active military service. Additional specific VBA criteria must be met.

### **Other Exam**

Two examples of other examination priorities are Appeal and BVA Remand. A Veteran or Servicemember who is dissatisfied with his or her rating decision can appeal that decision to VBA, and if the Veteran is dissatisfied with the appeal decision, he or she can continue their appeal upward to the Board of Veterans' Appeals (BVA), the U.S. Court of Appeals for Veterans Claims (CAVC), the U.S. Court of Appeals for the Federal Circuit, and finally to the U.S. Supreme Court. An appeal or remand may result in the need for an additional examination, or there may be a remand, or a request from BVA for VHA to re-examine the Veteran/Servicemember. The examiner may be asked to answer specific questions as detailed in the request.

## **P**

### **Peripheral Nerves**

The common peroneal nerve innervates the lateral leg and the dorsum of the foot; the tibial nerve innervates the sole. If a claimed condition relates to these areas, the examiner needs to specify which nerve is involved.

## **R**

### **Request for Examination (VA Form 21-2507)**

An electronic request for a disability examination is initiated by the VA Regional Office (VARO or RO). Examinations are requested after the Veteran has made a substantially complete application for disability benefits. The examination request should be reviewed in detail by the disability examiner prior to conducting the requested examination.

### **Review Exam**

An evaluation of a disability that has already been determined to be SC. But unlike an "increase" request, VBA initiates a "review" request to determine whether or not the current disability rating is still appropriate. (NOTE: For certain disabilities that are not static, VA is required to periodically re-evaluate their disabling effects on the Veteran.) When you conduct the examination, you should take a detailed history of the claimed condition(s) from the date of the last C&P exam until today.

## **RO**

Regional Office, a field office of the VBA which adjudicates claims to VA for benefits and delivers other services to Veterans/SMs. Also known as the VA Regional Office, or VARO.

## **RVSR**

Rating Veterans Service Representative, a VBA employee who, based on service and medical records, determines whether or not a claimed disability exists, the relationship of the disability to military service, and the degree to which it renders the Veteran or Servicemember disabled.

## **S**

### **Schedule for Rating Disabilities (38 Code of Federal Regulations, Part 4)**

VA's Schedule for Rating Disabilities is a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The ratings represent the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability. For the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition.

## **Secondary Service Connection**

An additional disability, which is proximately due to or the result of a SC disease or injury shall be SC. Additionally, any increase in severity of a NSC disease or injury that is proximately due to or the result of an SC disease or injury, and not due to the natural progress of the NSC disease, will be SC. However, VA will not concede that an NSC disease or injury was aggravated by an SC disease or injury unless the baseline level of severity of the NSC disease or injury is established by medical evidence.

## **Service-Connected (SC) Disability Compensation**

Refers to monetary benefits paid to Veterans or Servicemembers who are disabled by SC conditions (conditions related to military service). SC disability compensation benefits are intended to compensate for average loss of earning potential due to a current disability resulting from disease or injury which was incurred or aggravated (pre-military conditions) in active military service.

## **T**

### **Terminal Exam**

Requested when the Veteran/Servicemember's prognosis is poor. A Terminal exam request requires an expedited process. Completion of the examination and report by VHA, and adjudication by VBA, is expected to be accomplished within days of receiving the Veteran's/Servicemember's claim.

## **V**

### **VARO**

VA Regional office (See RO)

### **VBA**

Veterans Benefits Administration, the administration responsible for a wide variety of benefit programs authorized by Congress, including disability compensation, disability pension, burial assistance, rehabilitation assistance, education and training assistance, home loan guarantees, and life insurance coverage.

### **VHA**

Veterans Health Administration – VHA is the administration that provides health care for Veterans through nationwide VA Medical Centers (VAMCs). VHA manages one of the largest health care systems in the United States. VAMCs within a Veterans Integrated Service Network (VISN) work together to provide efficient, accessible health care to Veterans in their areas. VHA conducts research; is among the largest providers of health professional training in the world; is a principal Federal asset for providing medical assistance in major disasters; and serves as the largest direct-care provider for homeless citizens in the United States.

## **VSC**

Veterans Service Center, a field office of the VBA that adjudicates claims to VA benefits and delivers other services to Veterans.