State Veterans Affairs Board
P.O. Box 5947
Pearl, MS 39288-5947

STATEMENT OF ATTENDING PHYSICIAN FORM

VETERAN'S NAME: _____

VETERAN'S CLAIM #: _____

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GUARDIAN'S NAME: _____

RELATIONSHIP TO VETERAN: _____

GUARDIAN'S ADDRESS: _____
_____
_____

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PATIENT'S CURRENT SYMPTOMS AND COMPLAINTS

Diagnosis of Patient's Disabilities:

1. _____ Severity _____
2. _____ Severity _____
3. _____ Severity _____
4. _____ Severity _____
5. _____ Severity _____

HOW OFTEN AND UNDER WHAT CIRCUMSTANCE DOES PATIENT LEAVE HOME OR PREMISES?_____
_____
_____
_____

WHAT AIDS ARE REQUIRED FOR LOCOMOTION OR MOVEMENT?:

____ CANE ____ WALKER ____ BRACES
____ WHEEL CHAIR ____ CRUTCHES ____ LIFT CHAIR/SLING

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1. IS PATIENT BEDRIDDEN?_____

2. IS PATIENT BLIND?_____

3. IS THERE LOSS OF ANAL SPHINCTER CONTROL?_____

4. IS THERE LOSS OF BLADDER SPHINCTER CONTROL?_____

5. CAN PATIENT WALK AND GET AROUND WITHOUT ASSISTANCE?_____

6. CAN PATIENT DRESS AND UNDRESS WITHOUT ASSISTANCE? _____

7. CAN PATIENT USE THE BATH/TOILET WITHOUT ASSISTANCE?_____

8. CAN PATIENT WASH AND KEEP HIM/HERSELF CLEAN & PRESENTABLE?_____

9. CAN PATIENT FEED HIM/HERSELF WITHOUT ASSISTANCE?_____

10. CAN PATIENT PROTECT HIM/HERSELF FROM THE HAZARDS OF LIFE?_____

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IS PATIENT IN A NURSING HOME? _____

IF SO, WHAT LEVEL OF CARE? _____ PERSONAL CARE
_____ INTERMEDIATE CARE
_____ SKILLED

NAME OF NURSING HOME: _____
ADDRESS:_____
_____
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PHYSICIAN'S SIGNATURE: _____DATE: _____
ADDRESS OF PHYSICIAN:
_____
_____