Veterans Affairs Canada | Anciens Combattants Canada

Protected information when completed.

File No.:	Decision No.:
Service No(s).:	

Medical Questionnaire: Hemopoeitic Conditions

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

MEDICAL DIAGNOSIS(ES) OF CLAIMED/PENSIONED CONDITION(S) REQUIRING EXAMINATION:

1. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

2. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

3. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

Very specific information is required by Veterans Affairs Canada to evaluate and assess a client's claimed pensioned condition(s). As this information may not generally form part of the clinical history, please help us to collect this information by answering the following questions.

Please complete applicable sections only.

If additional recording space is required, please use the "additional comments" sheet.

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Injuries? ◯ Yes ◯ No **Describe (include dates)**

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate the nature of the test/consultation, and the appointment date (if known):

HIV/AIDS:

Please choose the appropriate statements:

☐ Intermittent clinical signs (except lymphadenopathy) and/or constitutional symptoms.
☐ Persistent clinical signs (except lymphadenopathy) and/or constitutional symptoms.
☐ Development of **one** AIDS defining opportunistic infection.

Please specify the type of infection and comment:

☐ Development of **more than one** episode of an AIDS defining opportunistic infection.

Please specify the type of infection and comment:

☐ Development of AIDS wasting syndrome.

CD4 count _____

Please elaborate on any positive responses:

PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS (E.G. DIAGNOSTIC, CONSULTATION, OPERATIVE, LABORATORY, HOSPITAL DISCHARGE SUMMARIES)

Family name:	Given name:	File No..

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g, physiotherapy).

Are transfusions required? ◯ Yes ◯ No
If yes , please specify frequency:

Is phlebotomy required? ◯ Yes ◯ No
If yes , please specify frequency:

COMPLICATIONS:
Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No
If yes, please provide details:

PHYSICAL EXAMINATION: (fill out only portion applicable to the pensioned/claimed condition(s))

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

GENERAL APPEARANCE:

EXAMINATION FINDINGS: Describe any relevant examination findings.

IF ADLs ARE AFFECTED ON A CONTINUOUS BASIS, DESPITE OPTIMAL TREATMENT, PLEASE COMPLETE THE ADL SECTION.

OTHER PERTINENT FINDINGS: (i.e. other conditions that may be contributing to the client's impairment)

Physician's signature:	Is VAC to be invoiced? ◯ Yes ◯ No	Telephone No. ( )	Today's date:

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Activities of Daily Living (ADL) Questionnaire

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

IF APPLICABLE TO THE CLAIMED/PENSIONED CONDITION(S), PLEASE COMPLETE THIS SHEET

Activities of Daily Living:

Please describe the impact that the pensioned conditions have on Activities of Daily Living.

Select the description that most accurately reflects the client's current level of functioning for each of the following activities:

Activity	Independent	Independent (with aids)	Requires reminders, prompting and/or supervision in addition to minor assistance	Needs extensive assistance	Totally dependent
Eating	◯	◯	◯	◯	◯
Bathing	◯	◯	◯	◯	◯
Grooming	◯	◯	◯	◯	◯
Dressing	◯	◯	◯	◯	◯
Toiletting	◯	◯	◯	◯	◯
Transferring	◯	◯	◯	◯	◯

Please elaborate (list aids required, ability to sit/stand unaided during task, safety concerns, bed mobility, etc.):

Continence/Incontinence:

Select the description that most accurately reflects the client's current level of bladder and bowel control:

	Continent (No assistance needed)	Occassional nighttime incontinence (once a week or less)	Daytime incontinence (more than once per week)	Daytime (daily) incontinence (requiring protective padding)	Daytime (daily) incontinence (requiring intervention by others)	Total incontinence
Bladder	◯	◯	◯	◯	◯	◯
Bowel	◯	◯	◯	◯	◯	◯

Comment: Please note the number of incontinence pads used/day, if applicable.

Locomotion: Please comment on any difficulty with walking, provide walking distance, and list aids required.

Chronic Pain: Please comment on pain intensity, frequency, symptoms and response to treatment.

Comments: Please remember to note other contributing conditions.

Physician's signature:	Today's date:

Family name:	Given name:	File No.:

Additional Comments:

Physician's signature:	Today's date: