



Veteran

UIN

Insert condition(s):

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

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

1. Please select the most accurate description of impairment to **active range of movement (ROM) of the thumb**, due to each condition *in isolation*.

Please rate the worst affected of the relevant joints. Consider motion in all planes of movement.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	Combined Conditions (if unable to isolate)
No loss or x-ray changes only.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minor loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of less than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of more than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complete loss (ankylosis).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR

2. Please select the most accurate description of impairment to **active range of movement (ROM) of the index finger**, due to each condition *in isolation*.
Please rate the worst of the IP and MP joints.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	OR	Combined Conditions (if unable to isolate)
No loss or x-ray changes only.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Minor loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of less than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of more than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Complete loss (ankylosis).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

3. Please select the most accurate description of impairment to **active range of movement (ROM) of the middle finger**, due to each condition *in isolation*.
Please rate the worst of the IP and MP joints.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	OR	Combined Conditions (if unable to isolate)
No loss or x-ray changes only.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Minor loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of less than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of more than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Complete loss (ankylosis).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

4. Please select the most accurate description of impairment to **active range of movement (ROM) of the ring finger**, due to each condition *in isolation*.
Please rate the worst of the IP and MP joints.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	OR	Combined Conditions (if unable to isolate)
No loss or x-ray changes only.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Minor loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of less than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of more than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Complete loss (ankylosis).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

5. Please select the most accurate description of impairment to **active range of movement (ROM) of the little finger**, due to each condition *in isolation*.
Please rate the worst of the IP and MP joints.

Description	Condition:	Condition:	Condition:	Condition:	Condition:	OR	Combined Conditions (if unable to isolate)
No loss or x-ray changes only.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Minor loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of less than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Loss of more than half normal range.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Complete loss (ankylosis).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

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

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

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

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

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

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

9. Please describe the **impact on self-care**, if any. Include specific activities affected (e.g. feeding, toileting) and which condition is causative.

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10. Please list the location and level of any **amputations** of the upper limb(s) arising from the hand and/or finger condition(s).

Location (body part and side)	Level (please be as specific as possible)	Indication

11. Are there any other comments you would like to make regarding the impact of the veteran’s hand and/or finger condition(s)?

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