VA File #: _____

Medical Statement

Aid & Attendance

(Circle the appropriate answer & explain in detail)

Veteran's Name: _____
LAST FIRST M.I.

Claimant's Name: _____
LAST FIRST M.I.

Address: _____
STREET APT CITY ST ZIP

1. Complete Diagnosis: _____

   _____

   _____

2. Is the claimant able to ambulate unaided? Yes No

   Describe: _____

   _____

3. Is the claimant able to feed himself/herself? Yes No

   Describe: _____

   _____

4. Does the claimant need personal care assistance (bathing, hygiene, etc)? Yes No

5. Is claimant able to toilet without assistance? Yes No

   Describe: _____

   _____

6. Is the claimant confined to bed? Yes No

   Describe: _____

   _____

7. Is the claimant able to sit up without assistance? Yes No

   Describe: _____

   _____

8. Is the claimant able to easily travel outside of the home unassisted? Yes No
   (If yes, estimate distance)

   Describe: _____

   _____

9. Is the claimant blind? Yes No

   Describe: _____

   _____

10. Does the claimant require care in a facility? Yes No

    Describe: _____

    _____

Describe other pertinent facts which show the claimant's need for daily assistance.

_____

_____

_____

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Physician's Name & Address

_____ _____

Physician's Signature

_____

_____ _____

Date

If necessary, attach copies of office or medical records concerning claimant's medical history