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| Australian Government crest, Department of Veterans' Affairs | Lower Limb(s) FunctionMedical Impairment Assessment |
| Veteran |  | UIN |
|  |  |  |
|  |  |  |
| Please assess the following conditions:  |

1. Please select the most accurate description of any impact on **walking pace**.

| **Description** | **Select One** |
| --- | --- |
| Walks in a manner **normal** for age **on a variety of different terrains**. |[ ]
| Walks at **normal** pace on **level ground**. |[ ]
| Walks at **moderately** **reduced pace** in comparison with peers on **flat ground**. |[ ]
| Walks at **significantly reduced pace** in comparison with peers. |[ ]
| Walks at **greatly reduced pace** in comparison with peers. |[ ]
| **Unable to walk or stand**. |[ ]

1. Please select the most accurate description with any **difficulty walking on uneven ground or steps**.

| **Description** | **Select One** |
| --- | --- |
| Walks in a manner **normal** for age **on a variety of different terrains**. |[ ]
| **Caution needed** on **steps and uneven ground**. |[ ]
| Has **constant difficulty** up and down **steps** and over **uneven ground**. |[ ]
| Is **unable** to manage stairs or ramps **without rails**. |[ ]
| Is **unable** to negotiate stairs **without personal assistance**. |[ ]
| Is **unable** to negotiate **kerbs**, **gutters** or **uneven ground**. |[ ]

1. Please select the most accurate description of how far the veteran can walk **before they must stop** **due to pain.** (The veteran may be able to walk further after resting).

| **Description** | **Select One** |
| --- | --- |
| **No limitation.** |[ ]
| **Intermittent pain from weight-bearing**, i.e., not all the time, or only after weight-bearing for some time. |[ ]
| **Pain restricts walking to 500m or less**, at a slow to moderate pace (4km/h). |[ ]
| **Pain restricts walking** (4km/h) **to 250m or less** at a time. |[ ]
| **Pain restricts walking** (4km/h) to **100m** **or less** at a time. |[ ]
| **Pain restricts walking** (4km/h) to **50m** **or less** at a time. |[ ]

1. Please select the most accurate description of any need for a **gait aid**.

| **Description** | **Select One** |
| --- | --- |
| Walks in a manner **normal** for age **on a variety of different terrains**. |[ ]
| Walks with **intermittent** difficulty, such as **locking or giving way, without falling**. |[ ]
| Legs give way frequently, resulting in falls. **Can walk** more efficiently with a **brace or an artificial limb**. |[ ]
| Is **restricted** to walking in home and around block. **Probably needs a walking aid**. |[ ]
| **Restricted** to walking in and around home **and** **requires** quad stick, crutches or similar **walking aid**. |[ ]
| **Restricted** to walking in and around home. **Can walk only with personal assistance, or with a walking aid such as a pickup frame.** |[ ]
| Mobile only in a **wheelchair.** |[ ]

1. Please select the most accurate description of any impact on **transfers**.

| **Description** | **Select One** |
| --- | --- |
| None. |[ ]
| Is **unable** to **rise** from the sitting position **without the assistance of one hand**. |[ ]
| Is **unable** to **rise** to standing position **without the assistance of both hands.** |[ ]
| Finds transfer **difficult without personal assistance.** |[ ]
| Is **unable** to transfer **without personal assistance**. |[ ]
| **Unable to walk or stand**. |[ ]

1. Please select the most accurate description of any **sciatic pain** associated with walking.

| **Description** | **Select One** |
| --- | --- |
| None. |[ ]
| **Occasional** twinges but no effect on walking most of the time. |[ ]
| Occurs **frequently**: present some of the time when walking. |[ ]
| **Daily** – present **most of the time during walking**. | [ ]  |

1. Please describe any **sensory loss or abnormality**.

| **Dermatome or peripheral nerve** | **Paraesthesia** | **Partial Loss** | **Total Loss** |
| --- | --- | --- | --- |
| **Side** | **Site** |  |  |  |
|  |  |[ ] [ ] [ ]
|  |  |[ ] [ ] [ ]
|  |  |[ ] [ ] [ ]
|  |  |[ ] [ ] [ ]

1. Please list the location and level of any **amputations** of the lower limbs.

| **Location** (body part and side) | **Level** (please be as specific as possible) |
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1. Are there any other comments you would like to make regarding the impact of the veteran’s lower limb condition(s)?

1. Please list **all conditions** contributing to the reported impairment and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

| **Condition** | **Contribution %** |
| --- | --- |
| e.g. Left Knee Osteoarthritis | 75% |
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|  |  |
| **Total** | **100%** |

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