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| Australian Government crest, Department of Veterans' Affairs branding | Neurological – Cranial Nerves  Medical Impairment Assessment | | | | | |
| Veteran | | |  | | UIN |
|  | |  | |  | | |
|  | | |  | |  |
| Please assess the following conditions:  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. | | | | | | |

For the purposes of this form, the terms “loss” and “loss of function” encompasses any dysfunction of the nerve which is evident on examination, including partial paralysis, or an alteration or partial loss of sensation, as well as complete loss of the relevant nerve function.

1. Please select the most accurate description of any **loss of function** of the **Olfactory (I) nerve**.

| **Description** | **Select One** |
| --- | --- |
| None. |  |
| **Unilateral** loss. |  |
| **Bilateral** loss. |  |

1. Please select the most accurate description of any **loss of function** of the **Optic (II) nerve.** Do *not* consider any impairment due to visual disorders, e.g. cataracts etc.

| **Description** | **Select One** |
| --- | --- |
| None. |  |
| **Unilateral** loss. |  |
| **Bilateral** loss. |  |

1. Please select the most accurate description of any **loss of function** of the **Oculomotor (III), Trochlear (IV)** and/or **Abducens (VI) nerves,** resulting in **diplopia**.

| **Description** | **Select One** |
| --- | --- |
| None. |  |
| **Unilateral** loss. |  |
| **Bilateral** loss. |  |

1. Please select **all** that apply for any **loss of function** of the **Trigeminal (V) nerve.** Do not include pain from trigeminal neuralgia (see question 6).

| **Description** | **Select** |
| --- | --- |
| None. |  |
| **Unilateral motor** loss. |  |
| **Unilateral sensory** loss. |  |
| **Bilateral motor** loss. |  |
| **Bilateral sensory** loss. |  |

1. Please select **all** that apply for any **loss of function** of the **Facial (VII) ner**v**e**.

| **Description** | **Select** |
| --- | --- |
| None. |  |
| **Complete** loss of taste. |  |
| **Unilateral** loss. |  |
| **Bilateral** loss**.** |  |

1. Please select **all** that apply in relation to any **facial pain**.

| **Description** | **Select** |
| --- | --- |
| None. |  |
| **Intractable typical trigeminal neuralgia**. |  |
| **Atypical facial neuralgia** (due to disorders of the Facial VII nerve). |  |

1. Please select the most accurate description of any **swallowing impairment** due to **loss of function** of the **cranial nerves**.

| **Description** | **Select One** |
| --- | --- |
| None. |  |
| Diet restricted to **semi-solid foods**. |  |
| Diet restricted to **liquid foods**. |  |
| Diet restricted to **tube feeding or gastrostomy**. |  |

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