

AID & ATTENDANCE LETTER Information is requested for the purpose of determining whether the veteran/spouse is capable of living independently or is in need of another person's help and care accomplishing the activities of daily living or is housebound.

Last First MI SS# C/CSS- VA Claim #

Diagnosis: _____

Medication/Treatment: _____

Prognosis: Good Fair Poor

If patient has vision impairment, please give degree of visual acuity: _____
(Entries such as light perception only, can count on fingers at x feet, are acceptable)

Patient needs help with the following: (please check appropriate box)

Dressing: Yes / No Bathing: Yes / No Walking: Yes / No

Transferring from bed to chair: Yes / No

Attending to the wants of nature: Yes / No
Patient is incontinent of: bowel Yes / No bladder Yes / No

Patient can use upper extremities: fully partially not at all

Patient can use lower extremities: fully partially not at all

Has left hemiplegia Yes / No Has right hemiplegia: Yes / No Dominant hand: right left

Capable of managing financial affairs: Yes / No If not, explain? _____

Can patient travel to the VA medical facility for care? Yes / No If not , explain? _____

Can patient live alone? Yes / No If not, explain? _____

Does patient need another in protecting himself/herself from the ordinary hazards of his/her daily environment? Yes / No
Effects of advance aging (dizziness , loss of memory , poor balance affects ability to ambulate , perform self-care , or travel beyond the premises of the home/ward/clinical area) Check all that applies.

Is the patient restricted to the home or the immediate vicinity thereof, including the ward or immediate clinical area, if hospitalized? Yes / No

Are there any additional comments on the back of this page? Yes / No

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____

Physician's Address: _____