

For this activity:

1. Please review the attached Service Treatment Records and identify all claimable conditions based on the records.
2. Please review the attached Hypertension Disability Benefits Questionnaire and identify any errors on the form. The form contains between 3-5 errors.

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: CLEMENS, SAMUEL

Date: 25 Jan 1999 1044 MST

Appt Type: WELL

Facility: Evans ACH Ft Carson, CO

Clinic: Welcome Center

Provider: JORDAN, MICHAEL

Patient Status: Outpatient

Reason for Appointment: in-processingAutoCitesProblems

- CONJUNCTIVITIS
- CONTACT DERMATITIS
- KNEE SPRAIN LEFT
- Need For Vaccination Hepatitis B
- Need For Vaccination Hepatitis A
- visit for: new patient eye exam
- TONSILLITIS
- OBESITY
- visit for: ears, nose, and throat exam
- visit for: military services physical

Active Family History

- Family medical history was unknown

Allergies

No Allergies Found.

Active Medications

No Active Medications Found.

ScreeningReason For Appointment: in-processingVitals

BP: 126/64 Adult Cuff, Left Arm, HR: 65 Radial Artery, Regular, HT: 71 in With Shoes, Actual, WT: 205 lbs Upright Scale, With Shoes, Actual, BMI: 28.59, BSA: 2.131 square meters, Tobacco Use: Yes, What type of tobacco product? cigars, Would you like to quit? Yes, Alcohol Use: Yes,

Past medical/surgical historyReported History:

Dietary: A high-fat diet.

Personal history

Alcohol: A social drinker

Habits: Good exercise habits

TestsBlood Chemistry:

Total serum cholesterol level was not elevated

Value
187A/P

1. Preventive Medicine New Patient Evaluation Adult 18-39

2. visit for: screening exam lipid disorders

3. tobacco use

4. visit for: screening exam hypertension

Procedure(s):

- Total Cholesterol
- Health And Behav Assessmt Each 15 Min Initial Assessment
- Blood Pressure \leq 140/90 mmHg
- Assessment & Intervention Blood Pressure Measured
- Anticipatory Guidance: Alcohol Use
- Anticipatory Guidance: Outdoor Safety Avoiding Sun Exposure
- Health Seminar on Smoking Cessation
- Maintain Healthy Diet
- Oral Fluids Frequent
- Patient Education - Injury Prevention
- Patient Education - Self-Examination Of Breasts
- Patient Education - Self-Examination Of Testes

Patient Instruction(s):

FMP/SSN: 20/123456789

DOB: 19670309

PCat: A11.2 ARMY ACTDUT

MC Status:

Insurance: No

Sex: M

Tel H: 719-246-0045

Tel W:

CS:

Status:

Sponsor/SSN:

CLEMENS, SAMUEL 123456789

Rank:

MAJ

Unit:

LEGAL/JAG23

Outpt Rec. Rm:

TRANS

PCM:

Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: ICLEMENS, SAMUEL

Date: 07 Nov 2000 0802 MST

Appt Type: SPEC\$

Treatment Facility: EVANS ACH

Clinic: ROBINSON TMC PHYSICAL
THERAPY

Provider: BURTON LAVARR

Patient Status: Outpatient

Reason for Appointment: LEFT ankle pain.

AutoCitesAllergies

• No Known Allergies

Active Medications

No Active Medications Found.

Vitals

Pain Scale: 5/10 Moderate, Pain Scale Comments: LEFT ankle

SO NoteChief complaint

The Chief Complaint is: LEFT ankle pain.

History of present illness

He reported: Past medical history reviewed, problem list reviewed, medication list reviewed, and surgical history reviewed.

Past medical/surgical historyReported History:

No recent change in medical history.

Personal history

No barriers to learning identified

No age specific concerns identified

No emotional barriers to treatment/therapy identified

No religious/cultural barriers to treatment/therapy identified.

Subjective

CURRENT HISTORY: reports twisting ankle x6 days ago while running, felt/heard 'pop', was able to walk with a limp.

Demonstrates inversion type injury

PAST HISTORY: similar injury x3-4wks ago while ruck marching,, treated as inversion sprain

PREVIOUS Rx/THERAPY: RICE, self-care

AGGRAVATING FACTORS: walking, running

EASING FACTORS: rest, ice

PNT DESCRIBES PAIN AS: (X) sharp, () dull, () ache, () burning, () numb/tingling, () other:

SPECIAL QUESTIONS/RED FLAGS: (X) swelling, (X) popping/snapping, (-) catching/locking, (+/-) instability, (-) bruising,
(-) other:

MOS/JOB: 88M

Physical findingsGeneral appearance:

• Well-appearing. • In no acute distress.

Musculoskeletal system:

Ankle:

Right ankle: • Examined.

Left ankle: • Examined.

Objective

GAIT: min. antalgic gait LLE

POSTURE/ALIGNMENT: WNL

EFFUSION/EDEMA: min/mod

Sex: M

Tel H: 719-246-0045

Tel W:

CS:

Sponsor/SSN: CLEMENS, SAMUEL 123456789

Rank: MAJ

Unit: LEGAL/JAG23

Outpt Rec. Rm: TRANS

FMP/SSN: 20/123456789

DOB: 19670309

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CHRONOLOGICAL RECORD OF MEDICAL CARE

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HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

Facility: Evans ACH Ft Carson, CO Clinic: Robinson Tmc Physical Therapy

ECCYMOSIS: none

FUNCTIONAL TESTS: (X) Heel walking intact L4-S1, (X) Toe walking intact S1-S2, (X) Able to perform SL heel raises x10 BLE, (X) SL stance >30 sec BLE w/ EO

MSR/DTR: not tested

SENSATION: intact to light touch & =/BLE

ROM: AROM WNL -- painful

PALPATION: TTP at ATFL / anterolateral LEFT ankle

GMMT: BLE 5/5 Grossly

ANKLE STABILITY TESTS: (+/-) Drawer, (-) Tilt, (-) ER stress

TIB-FIB SQUEEZE: Painfree

CLEARED: Knees cleared

MANUAL THERAPY TODAY: none

MODALITIES TODAY: none

EDUCATION/SELF CARE: (X) Advised on foot/ankle self-care, use of ice, NSAIDS, and activity modification, (X) Instructed in therapeutic exercises, (X) Advised on running shoe selection, (X) Other:

Patient was provided verbal & written instructions (handouts)

VERIFIED: Patient demonstrated/verbalized understanding of self-care/HEP

PNT GOAL: run painfree

STG: indep HEP/self-care -- demonstrated today; able to demonstrate next encounter; maintain pain <4/10 x4wks

LTG: full duty/activity, able to run x2 miles painfree; indep HEP/self-care progression x6wks.

A/P

1. ankle joint pain: LEFT ankle c/w inversion sprain (re-injury / aggravation f

Procedure(s):

-Physical Medicine Physical Therapy Evaluation x 1

-Phys Therapy Education Self Care Training - Per 15 Minutes x 1

-Physical Therapy: ___ Session Segments, 15 Minutes Each x 1

Patient Instruction(s):

-Options Orthopedic Modify Activity

-Physical Therapy Education Home Exercise Program

-Physical Therapy Home Exercises For Range Of Motion

-Physical Therapy Home Exercises For Strengthening

2. Other Physical Therapy

3. visit for: military services physical(

Disposition

Released w/ Work/Duty Limitations: Profile: ankle joint pain 719.47 march

Comment: no run, jump,

Follow up: as needed in 4 to 6 week(s) for therapy BIW x 2 to 3 week(s) in the ROBINSON TMC PHYSICAL THERAPY clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 45 minutes face-to-face/floor time..

FMP/SSN: 20/123456789
DOB: 19670309
PCat: A11.2 ARMY ACTDUTSex: M
Tel H: 719-246-0045
Tel W:
CS:Sponsor/SSN: CLEMENS, SAMUEL 123456789
Rank: MAJ
Unit: LEGAL/JAG23
Outpt Rec. Rm: TRANSMC Status:
Insurance: No

Status:

PCM:
Tel. PCM:



NAME OF CLAIMANT/VETERAN

CLAIMANT/VETERAN'S SOCIAL SECURITY NUMBER:

DATE OF EXAMINATION:

NOTE TO EXAMINER - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA 21-2507, C&P EXAMINATION REQUEST?

☐ Yes ☐ No

How was the examination completed? (check all that apply)

- ☐ In-person examination
☐ Records reviewed
☐ Examination via approved video telehealth
☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

- ☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.
- ☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED (check all that apply):

- ☐ Not requested ☐ No records were reviewed
☐ VA claims file (hard copy paper C-file)
☐ VA e-folder
☐ VA electronic health record
☐ Other (please identify other evidence reviewed):

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN CURRENTLY HAVE A DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION BASED ON THE FOLLOWING CRITERIA?

NOTE 1: For VA disability rating purposes, the term hypertension means that the diastolic blood pressure is predominantly 90mm or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm or greater with a diastolic blood pressure of less than 90mm.

NOTE 2: For VA purposes, the INITIAL diagnosis of hypertension or isolated systolic hypertension must be confirmed by readings taken 2 or more times on at least 3 different days. Blood pressure results may be obtained from existing medical records or through scheduled visits for blood pressure measurements.

☐ Yes ☐ No (If yes, provide only diagnoses that pertain to hypertension):

☐ Hypertension ICD code: _____ Date of diagnosis: _____

☐ Isolated systolic hypertension ICD code: _____ Date of diagnosis: _____

☐ Other, specify: _____

Other diagnosis #1: _____ ICD code: _____ Date of diagnosis: _____

Other diagnosis #2: _____ ICD code: _____ Date of diagnosis: _____

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION, LIST USING ABOVE FORMAT:

NOTE 3: ALSO complete appropriate questionnaires for hypertension-related complications, if any (such as Kidney, if renal insufficiency is attributable to hypertension).

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S HYPERTENSION CONDITION (Brief summary):

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION?

☐ Yes ☐ No (If yes, list only those medications used for the diagnosed conditions):

2C. WAS THE VETERAN'S INITIAL DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION CONFIRMED BY BLOOD PRESSURE READINGS TAKEN 2 OR MORE TIMES ON AT LEAST 3 DIFFERENT DAYS?

☐ Yes ☐ No ☐ Unknown (If checked, proceed to questions 2D and 2E)

(If yes, provide BP readings used to establish initial diagnosis, if known)

Reading # 1:	Reading # 2:	Date of Reading:
Reading # 1:	Reading # 2:	Date of Reading:
Reading # 1:	Reading # 2:	Date of Reading:

(If no, report BP readings taken 2 or more times on at least 3 different days in order to confirm diagnosis (unless Veteran is on treatment for hypertension.))

Reading # 1:	Reading # 2:	Date of Reading:
Reading # 1:	Reading # 2:	Date of Reading:
Reading # 1:	Reading # 2:	Date of Reading:

2D. DOES THE VETERAN HAVE A HISTORY OF A DIASTOLIC BP ELEVATION TO PREDOMINANTLY 100 OR MORE?

☐ Yes ☐ No (If yes, describe frequency and severity of diastolic BP elevation):

2E. CURRENT (DATE OF EVALUATION/S) BLOOD PRESSURE READINGS** (SUFFICIENT IF VETERAN HAS A PREVIOUSLY ESTABLISHED DIAGNOSIS OF HYPERTENSION):

Reading # 1:	Date of Reading:	**The Veteran should be seated comfortably with back and feet supported. There is no need to take lying or standing blood pressures. There is no specified time interval between readings and they may be completed sequentially.
Reading # 2:	Date of Reading:	
Reading # 3:	Date of Reading:	

SECTION III - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

3A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ Yes ☐ No

If yes, describe (brief summary):

3B. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ Yes ☐ No

(If yes, also complete appropriate dermatological DBQ)

3C. COMMENTS, IF ANY:

SECTION IV - FUNCTIONAL IMPACT

4A. DOES THE VETERAN'S HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION IMPACT HIS OR HER ABILITY TO WORK?

☐ Yes ☐ No (If yes, describe the impact of the veteran's hypertension or isolated systolic hypertension, providing one or more examples):

SECTION V - REMARKS

5A. REMARKS (IF ANY):

SECTION VI - EXAMINER'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

6A. EXAMINER'S SIGNATURE

6B. EXAMINER'S PRINTED NAME

6C. DATE SIGNED

6D. EXAMINER'S PHONE AND FAX NUMBER

6E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

6F. MEDICAL LICENSE NUMBER AND STATE

6G. EXAMINER'S ADDRESS