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Eating Disorders Examination
Comprehensive Worksheet

Name: _____ SSN: _____

Date of Exam: _____ C-number: _____

Place of Exam: _____

The following health care providers can perform initial examinations for Eating Disorders:

*a board-certified or board "eligible" psychiatrist;
a licensed doctorate-level psychologist;
a doctorate-level mental health provider under the close supervision of a board-certified or board eligible psychiatrist or licensed doctorate-level psychologist;
a psychiatry resident under close supervision of a board-certified or board eligible psychiatrist or licensed doctorate-level psychologist;
or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board eligible psychiatrist or licensed doctorate-level psychologist.*

The following health care providers can perform review examinations for Eating Disorders:

*a board-certified or board "eligible" psychiatrist;
a licensed doctorate-level psychologist;
a doctorate-level mental health provider under close supervision of a board-certified or board eligible psychiatrist or licensed doctorate-level psychologist;
a psychiatry resident under close supervision of a board-certified or board eligible psychiatrist or licensed doctorate-level psychologist;
a clinical or counseling psychologist completing a one year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board eligible psychiatrist or licensed doctorate-level psychologist;
a licensed clinical social worker (LCSW); or
a nurse practitioner (NP), a clinical nurse specialist or physician assistant, if they are clinically privileged to perform activities required for C&P mental disorder examinations, under close supervision of a board-certified or board eligible psychiatrist or licensed doctorate-level psychologist.*

A. Review of Medical Records:

B. Medical History (Subjective Complaints):

Review examination. If this is a review examination for an already

service-connected eating disorder, provide the medical and occupational history since the last medical examination. Otherwise, follow the history requirements below.

Comment on:

1. Onset. Date of onset of condition, and circumstances and initial manifestations.
2. Course of condition since onset.
3. Treatment. Current treatment, response to treatment, and any side effects.
4. Hospitalizations or surgery. History of related hospitalizations or surgery, dates and location, if known, reason or type of surgery.
5. State number of hospitalizations required per year for parenteral nutrition or tube feeding.
6. Periods of incapacitation. State whether there have been periods of incapacitation (requiring bed rest and treatment by a physician) because of an eating disorder. If so, state the frequency and duration of the episodes (in days) and the total duration of days of incapacitation during the past 12-month period.
7. Binge eating. State whether there is a history of binge eating. If there is, state the frequency and extent over the past 12-month period.
8. Self-induced vomiting. State if there is a history of self-induced vomiting or other measure to prevent weight gain when weight is already below expected minimum normal weight. If so, state frequency and extent over past 12-month period.
9. Other current symptoms. Report other current (during past 12 months) symptoms of an eating disorder, such as amenorrhea, abdominal pain, lethargy, cold intolerance, disturbance in perception of body shape or size, etc., and other significant history.

C. Examination (Objective Findings):

Address each of the following and fully describe:

1. Weight-related issues
 - a. Current weight and height.
 - b. Expected minimum weight based on age, height, and body build.
 - c. Pertinent weight history.
 - d. Percent of weight loss or gain compared to baseline (average weight in the 2 years preceding onset of the condition).
2. Other significant findings on physical examination.

D. Diagnostic and Clinical Tests:

1. Conduct psychological testing if deemed necessary.
2. CBC, blood chemistry, EKG, renal function tests, or other studies, as indicated.
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:

1. State whether the DSM-IV criteria for a diagnosis of anorexia nervosa have been met.
2. State whether the DSM-IV criteria for a diagnosis of bulimia nervosa have been met.
3. State whether the DSM-IV criteria for a diagnosis of eating disorder not otherwise specified have been met.
4. State any comments on the DSM-IV criteria.
5. For each diagnosis, state effects of the condition on occupational functioning and daily activities.
6. **Capacity to handle financial affairs.** Mental competency, for VA benefits purposes, refers only to the ability of the veteran to manage VA benefit payments in his or her own best interest, and not to any other subject. Mental incompetency, for VA benefits purposes, means that the veteran, because of injury or disease, is not capable of managing benefit payments in his or her best interest. In order to assist raters in making a legal determination as to competency, please address the following:

What is the impact of injury or disease on the veteran's ability to manage his or her financial affairs, including consideration of such things as knowing the amount of his or her VA benefit payment, knowing the amounts and types of bills owed monthly, and handling the payment prudently? Does the veteran handle the money and pay the bills himself or herself?

Based on your examination, do you believe that the veteran is capable of managing his or her financial affairs? Please provide examples to support your conclusion.

If you believe a Social Work Service assessment is needed before you can give your opinion on the veteran's ability to manage his or her financial affairs, please explain why.

Include your name; your credentials, (i.e., a board certified psychiatrist, a licensed psychologist, a psychiatry resident or a psychology intern, LCSW, or NP); and circumstances under which you performed the examination, if applicable (i.e., under the close supervision of an attending psychiatrist or psychologist); include name of supervising psychiatrist or psychologist.

Signature:

Date:

Signature of Supervising psychiatrist or psychologist:

Date: