

Specialty Examination – NEUROLOGY

In instances when a Specialty Examination is requested, the Contractor shall provide the DDDS and its DDDS claimants with the following, in addition to, the Adult General Medical Disability Evaluation and Report Guidelines.

The examination should concentrate on the areas affected by the DDDS claimant's illness or impairment. Provide specific information and be as descriptive as possible.

(1) Neurological Examination.

- (a) Current Medical History. Describe and discuss:
 - i. Cognitive impairment
 - ii. Motor weakness
 - iii. Sensory abnormalities
 - iv. Problems with speech
 - v. Problems with swallowing
 - vi. Problems with voiding and defecation
 - vii. Cooperation with taking medication as prescribed and response to treatment
 - viii. Blood levels, if available
 - ix. Headaches. Include known triggers, frequency, length and response to treatment
- (b) Coordination
 - i. Abnormal movements
 - ii. Tremors
 - iii. Incoordination
- (c) Motor Function
 - i. Describe all motor function in quantitative terms and method of quantification
 - ii. Comment on degree of fatigability following rapid, repetitive movements
 - iii. Describe and atrophy, flaccidity, spasticity, rigidity, limitation of movement, and fatigability of extremities
- (d) Alleged Fatigue (i.e. myasthenia gravis)
 - i. Test for ability to fatigue by exercise (i.e. ptosis develops after 1-minute of attempted up gaze or strength declines from 5/5 at rest to 2/5 after 10-minutes of exercise of a particular muscle)
- (e) Cranial Nerve Functions
 - i. Visual acuity and confrontation visual fields
 - ii. Pupillary responses to light and accommodation
 - iii. Examination of extraocular movements or presence of nystagmus
 - iv. Facial sensation including corneal reflex and masseter strength and bulk
 - v. Facial muscle strength and symmetry
 - vi. Hearing Test
 - vii. Other functions as appropriate such as gag reflex, neck muscle strength, ability to detect odors, and tongue movement (strength or atrophy)
- (f) Sensory Function
 - i. Pattern. Anatomic or non-anatomic
 - ii. Characteristics of any type of pain and relationship to underlying disorder
- (g) Mental Status Exam. Describe and give examples of:
 - i. Orientation
 - ii. Memory
 - iii. Calculation
 - iv. Insight
 - v. General understanding

- vi. Fund of knowledge
- vii. Mood and behavior
- (h) Speech. Describe:
 - i. Intelligibility and fluency
 - ii. Aphasia. Including ability to comprehend language or produce language either spoken or written
 - iii. Dysarthria
 - iv. Stuttering
 - v. Involuntary vocalizations
- (i) Seizures. Provide complete description, including:
 - i. Type and severity
 - ii. Auras
 - iii. Behavior prior to seizure
 - iv. Diurnal or nocturnal
 - v. Frequency per month during the past year
 - vi. Duration of episodes
 - vii. Postictal phenomena
 - viii. Dates of last three seizures