



NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

**IMPORTANT** - THE DEPARTMENT OF VETERANS AFFAIRS (VA) **WILL NOT PAY OR REIMBURSE** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - 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. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL Questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Other, please describe:

Are you a VA Healthcare provider?  Yes  No

Is the Veteran regularly seen as a patient in your clinic?  Yes  No

Was the Veteran examined in person?  Yes  No

If no, how was the examination conducted?

**EVIDENCE REVIEW**

Evidence reviewed:

No records were reviewed

Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

**SECTION I - DIAGNOSIS**

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A GALLBLADDER OR PANCREAS CONDITION?

YES  NO (If "Yes," complete Item 1B)

1B. SELECT THE VETERAN'S CONDITION (check all that apply):

- |   |                 |                          |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Cholecystitis, chronic   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Cholelithiasis, chronic  | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Cholangitis, chronic   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Cholecystectomy (gallbladder, removal of)  | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Pancreatitis   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Total pancreatectomy   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Partial pancreatectomy   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Gallbladder neoplasm   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Pancreatic neoplasm  | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Gallbladder or pancreas injury, with peritoneal adhesions resulting from this injury | ICD Code: _____ | Date of Diagnosis: _____ |
- (If checked, ALSO complete the Peritoneal Adhesions Questionnaire)
- Other gallbladder conditions:  
Other Diagnosis #1: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
Other Diagnosis #2: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO GALLBLADDER OR PANCREAS CONDITIONS, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S GALLBLADDER OR PANCREAS CONDITION?

YES  NO (If "Yes," list only those medications required for the gallbladder or pancreas condition):

**SECTION III - GALLBLADDER CONDITIONS: SIGNS AND SYMPTOMS**

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY GALLBLADDER CONDITIONS OR RESIDUALS OF TREATMENT FOR GALLBLADDER CONDITIONS?

YES  NO

(If "Yes," check all that apply):

- Gallbladder dyspepsia confirmed by X-ray  
(If checked, indicate number of episodes per year):  
 0  1  2  3  4 or more
- Attacks gallbladder colic  
(If checked, indicate number of attacks per year):  
 0  1  2  3  4 or more
- Frequent attacks gallbladder colic
- Infrequent attacks (not over two or three a year) of gallbladder colic  
 Mild symptoms  Moderate symptoms  Severe symptoms
- Cholecystectomy post operative residuals:  
 Asymptomatic  Mild symptoms  Severe symptoms
- Jaundice  
(If checked, provide bilirubin level in Diagnostic Testing section)
- Other signs or symptoms, describe: \_\_\_\_\_

**SECTION IV - PANCREAS CONDITIONS: SIGNS AND SYMPTOMS**

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SYMPTOMS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

YES  NO

(If "Yes," check all that apply):

Abdominal pain, confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies

(If checked, indicate severity and frequency of attacks, check all that apply):

Mild (typical)  Moderately Severe  Severe (disabling)

(Indicate number of attacks of MILD (TYPICAL) abdominal pain in the past 12 months):

0  1  2  3  4  5  6  7  8 or more

(Indicate number of attacks of MODERATELY SEVERE abdominal pain in the past 12 months):

0  1  2  3  4  5  6  7  8 or more

(Indicate number of attacks of SEVERE (DISABLING) abdominal pain in the past 12 months):

0  1  2  3  4  5  6  7  8 or more

Remissions/pain-free intermissions between attacks

(If checked, indicate characteristics of remissions):

Good pain-free remissions between attacks

Few pain-free intermissions between attacks

Other findings showing continuing pancreatic insufficiency between attacks

Other symptoms, describe: \_\_\_\_\_

4B. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR FINDINGS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

YES  NO

(If "Yes," check all that apply):

Steatorrhea

(If checked, describe frequency and severity): \_\_\_\_\_

Malabsorption

(If checked, describe frequency and severity): \_\_\_\_\_

Diarrhea

(If checked, describe frequency and severity): \_\_\_\_\_

Severe malnutrition

(If checked, describe deficiency (such as beta-carotene, fat-soluble vitamin deficiencies)): \_\_\_\_\_

Loss of normal body weight

(If checked, provide baseline weight: \_\_\_\_\_ and current weight: \_\_\_\_\_).

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease).

Other, describe: \_\_\_\_\_

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

5A. 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):

5B. 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, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (6 square inches); OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

YES  NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: \_\_\_\_\_ MEASUREMENTS: length \_\_\_\_\_ cm X width \_\_\_\_\_ cm.

**NOTE:** If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

5C. COMMENTS, IF ANY:

**SECTION VI - DIAGNOSTIC TESTING**

**NOTE:** Diagnosis of pancreatitis must be confirmed by appropriate laboratory and clinical studies. If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

6A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO

*(If "Yes," check all that apply):*

- |   |             |                |
|---|-------------|----------------|
| <input type="checkbox"/> EUS ( <i>Endoscopic ultrasound</i> )                               | Date: _____ | Results: _____ |
| <input type="checkbox"/> ERCP ( <i>Endoscopic retrograde cholangiopancreatography</i> )     | Date: _____ | Results: _____ |
| <input type="checkbox"/> Transhepatic cholangiogram   | Date: _____ | Results: _____ |
| <input type="checkbox"/> MRI or MRCP ( <i>magnetic resonance cholangiopancreatography</i> ) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Gallbladder scan ( <i>HIDA scan or cholescintigraphy</i> )         | Date: _____ | Results: _____ |
| <input type="checkbox"/> CT   | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other, specify: _____  | Date: _____ | Results: _____ |

6B. HAS LABORATORY TESTING BEEN PERFORMED?

YES  NO

*(If "Yes," check all that apply):*

- |  |             |                |
|--|-------------|----------------|
| <input type="checkbox"/> Alkaline phosphatase  | Date: _____ | Results: _____ |
| <input type="checkbox"/> Bilirubin             | Date: _____ | Results: _____ |
| <input type="checkbox"/> WBC                   | Date: _____ | Results: _____ |
| <input type="checkbox"/> Amylase               | Date: _____ | Results: _____ |
| <input type="checkbox"/> Lipase                | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other, specify: _____ | Date: _____ | Results: _____ |

6C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES  NO

*(If "Yes," provide type of test or procedure, date and results in a brief summary):*

**SECTION VII - FUNCTIONAL IMPACT**

7. DOES THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION(S) IMPACT ON HIS OR HER ABILITY TO WORK?

YES  NO *(If "Yes," describe the impact of each of the Veteran's gallbladder and/or pancreas conditions, providing one or more examples):*

**SECTION VIII - REMARKS**

8. REMARKS *(If any)*

**SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

9A. PHYSICIAN'S SIGNATURE

9B. PHYSICIAN'S PRINTED NAME

9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBER

9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

9F. PHYSICIAN'S ADDRESS