



INTESTINAL CONDITIONS (OTHER THAN SURGICAL OR INFECTIOUS) (INCLUDING IRRITABLE BOWEL SYNDROME, CROHN'S DISEASE, ULCERATIVE COLITIS, AND DIVERTICULITIS) DISABILITY BENEFITS QUESTIONNAIRE

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:

Text input box for describing other requestor.

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?

Text input box for describing examination method.

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.

Large text input box for identifying evidence reviewed.

**SECTION I - DIAGNOSIS**

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN INTESTINAL CONDITION (other than surgical or infectious)?

YES  NO If "Yes," complete Item 1B

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

- |   |                 |                          |
|---|-----------------|--------------------------|
| <input type="checkbox"/> IRRITABLE BOWEL SYNDROME   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> SPASTIC COLITIS  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> MUCOUS COLITIS   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> CHRONIC DIARRHEA   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> ULCERATIVE COLITIS   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> CROHN'S DISEASE  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> CHRONIC ENTERITIS  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> CHRONIC ENTEROCOLITIS  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> CELIAC DISEASE   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> DIVERTICULITIS   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> INTESTINAL NEOPLASM  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> PERITONEAL ADHESIONS ATTRIBUTABLE TO DIVERTICULITIS.<br>IF CHECKED, ALSO COMPLETE Peritoneal Adhesions Questionnaire | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> OTHER NON-SURGICAL OR NON-INFECTIOUS INTESTINAL CONDITIONS:<br>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 INTESTINAL CONDITIONS (other than surgical or infectious), LIST USING THE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S INTESTINAL CONDITION (Brief summary)

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

YES  NO

IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR THE INTESTINAL CONDITION

2C. HAS THE VETERAN HAD SURGICAL TREATMENT FOR AN INTESTINAL CONDITION?

YES  NO

IF YES, ALSO COMPLETE THE INTESTINAL SURGERY QUESTIONNAIRE

**SECTION III - SIGNS AND SYMPTOMS**

3. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY NON-SURGICAL NON-INFECTIOUS INTESTINAL CONDITIONS?

YES  NO If "Yes," check all that apply

DIARRHEA (If checked, describe)

ALTERNATING DIARRHEA AND CONSTIPATION (If checked, describe)

ABDOMINAL DISTENSION (If checked, describe)

ANEMIA (If checked, provide hemoglobin/hematocrit in Section IX, Diagnostic Testing)

NAUSEA (If checked, describe)

VOMITING (If checked, describe)

OTHER (If checked, describe)

**SECTION IV - SYMPTOM EPISODES, ATTACKS AND EXACERBATIONS**

4. DOES THE VETERAN HAVE EPISODES OF BOWEL DISTURBANCE WITH ABDOMINAL DISTRESS, OR EXACERBATIONS OR ATTACKS OF THE INTESTINAL CONDITION?

YES  NO IF YES, INDICATE SEVERITY AND FREQUENCY (Check all that apply)

Episodes of bowel disturbance with abdominal distress

If checked, indicate frequency

Occasional episodes

Frequent episodes

More or less constant abdominal distress

Episodes of exacerbations and/or attacks of the intestinal condition. If checked, describe typical exacerbation or attack

Indicate number of exacerbations and/or attacks in past 12 months

0  1  2  3  4  5  6  7 or more

**SECTION V - WEIGHT LOSS**

5. DOES THE VETERAN HAVE WEIGHT LOSS ATTRIBUTABLE TO AN INTESTINAL CONDITION (other than surgical or infectious condition)?

YES  NO

If "Yes," provide Veteran's baseline weight: \_\_\_\_\_ and current weight: \_\_\_\_\_

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

**SECTION VI - MALNUTRITION, COMPLICATIONS AND OTHER GENERAL HEALTH EFFECTS**

6. DOES THE VETERAN HAVE MALNUTRITION, SERIOUS COMPLICATIONS OR OTHER GENERAL HEALTH EFFECTS ATTRIBUTABLE TO THE INTESTINAL CONDITION?

YES  NO If "Yes," indicate findings) (Check all that apply)

Health only fair during remissions

General debility

Serious complication such as liver abscess (Describe)

Malnutrition. If checked, is malnutrition marked?  YES  NO

Other (Describe)

NOTE: Complete additional Disability Benefits Questionnaire(s) for complications noted, as deemed appropriate (schedule with appropriate provider).

**SECTION VII - TUMORS AND NEOPLASMS**

7A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

YES  NO If "Yes," complete the following:

7B. IS THE NEOPLASM

BENIGN  MALIGNANT

7C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

YES  NO, WATCHFUL WAITING

IF YES, INDICATE TYPE OF TREATMENT THE VETERAN IS CURRENTLY UNDERGOING OR HAS COMPLETED (Check all that apply)

Treatment completed, currently in watchful waiting status

Surgery (If checked, describe) \_\_\_\_\_

Date(s) of surgery: \_\_\_\_\_

Radiation therapy

Date of most recent treatment: \_\_\_\_\_ Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Antineoplastic chemotherapy

Date of most recent treatment: \_\_\_\_\_ Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Other therapeutic procedure (If checked, describe procedure) \_\_\_\_\_

Date of most recent procedure: \_\_\_\_\_

Other therapeutic treatment (If checked, describe treatment) \_\_\_\_\_

Date of completion of treatment or anticipated date of completion \_\_\_\_\_

7D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (including metastases) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

YES  NO IF YES, LIST RESIDUAL CONDITIONS AND COMPLICATIONS (Brief summary)

7E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

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

8A. 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):

**SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS (continued)**

8B. 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.

8C. COMMENTS, IF ANY:

**SECTION IX - DIAGNOSTIC TESTING**

NOTE: If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the veteran's current condition, provide most recent results; no further studies or testing are required for this examination.

9A. HAS LABORATORY TESTING BEEN PERFORMED?

YES  NO If "Yes," check all that apply

CBC (If anemia due to any intestinal condition is suspected or present)

Date of test: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ Hematocrit: \_\_\_\_\_ White blood cell count: \_\_\_\_\_ Platelets: \_\_\_\_\_

Other (Specify) \_\_\_\_\_

Date of test: \_\_\_\_\_

Results: \_\_\_\_\_

9B. HAVE IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (Brief summary)

9C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES  NO IF YES, DESCRIBE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (Brief summary)

**SECTION X - FUNCTIONAL IMPACT**

10. DOES THE VETERAN'S INTESTINAL CONDITION IMPACT HIS OR HER ABILITY TO WORK?

YES     NO    IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S INTESTINAL CONDITIONS, PROVIDING ONE OR MORE EXAMPLES

**SECTION XI - REMARKS**

11. REMARKS (If any)

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

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

12A. PHYSICIAN'S SIGNATURE	12B. PHYSICIAN'S PRINTED NAME	12C. DATE SIGNED
12D. PHYSICIAN'S PHONE AND FAX NUMBER	12E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	12F. PHYSICIAN'S ADDRESS