Department of Veterans Affairs

PROSTATE CANCER 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

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 EVER BEEN DIAGNOSED WITH PROSTATE CANCER?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO PROSTATE CANCER

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO PROSTATE CANCER, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S PROSTATE CANCER CONDITION *(Brief summary)*

2B. INDICATE STATUS OF THE DISEASE

☐ ACTIVE ☐ REMISSION

SECTION III - TREATMENT

3. HAS THE VETERAN COMPLETED ANY TREATMENT FOR PROSTATE CANCER OR IS THE VETERAN CURRENTLY UNDERGOING ANY TREATMENT FOR PROSTATE CANCER?

☐ YES ☐ NO, WATCHFUL WAITING *(If "Yes," specify treatment type(s)) (Check all that apply)*

- ☐ TREATMENT COMPLETED, CURRENTLY IN WATCHFUL WAITING STATUS
- ☐ SURGERY
  - ☐ PROSTATECTOMY
    - ☐ RADICAL PROSTATECTOMY
    - ☐ TRANSURETHRAL RESECTION PROSTATECTOMY
    - ☐ OTHER *(DESCRIBE):* ____________
  - ☐ OTHER SURGICAL PROCEDURE *(DESCRIBE):* ____________ *(DATE OF SURGERY):* ____________
- ☐ RADIATION THERAPY *(DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION):* ____________
- ☐ BRACHYTHERAPY *(DATE OF TREATMENT):* ____________
- ☐ ANTINEOPLASTIC CHEMOTHERAPY *(DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION)*: ____________
- ☐ ANDROGEN DEPRIVATION THERAPY *(HORMONAL THERAPY) (DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION)*: ____________
- ☐ OTHER THERAPEUTIC PROCEDURE AND/OR TREATMENT *(DESCRIBE):* ____________

  (DATE OF PROCEDURE):

  (DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION): ____________

SECTION IV - VOIDING DYSFUNCTION

4. DOES THE VETERAN HAVE A VOIDING DYSFUNCTION?

☐ YES ☐ NO *(If "Yes," provide etiology of voiding dysfunction)* ____________

(If the veteran has a voiding dysfunction, complete Items 4A through 4D)

A. DOES THE VOIDING DYSFUNCTION CAUSE URINE LEAKAGE?

☐ YES ☐ NO

INDICATE SEVERITY *(Check one)*

- ☐ DOES NOT REQUIRE THE WEARING OF ABSORBENT MATERIAL
- ☐ REQUIRES ABSORBENT MATERIAL WHICH MUST BE CHANGED LESS THAN 2 TIMES PER DAY
- ☐ REQUIRES ABSORBENT MATERIAL WHICH MUST BE CHANGED 2 TO 4 TIMES PER DAY
- ☐ REQUIRES ABSORBENT MATERIAL WHICH MUST BE CHANGED MORE THAN 4 TIMES PER DAY
- ☐ OTHER *(Describe)* ____________

SECTION IV - VOIDING DYSFUNCTION *(Continued)*

B. DOES THE VOIDING DYSFUNCTION REQUIRE THE USE OF AN APPLIANCE?

☐ YES ☐ NO *(If "Yes," describe the appliance)* ____________________

C. DOES THE VOIDING DYSFUNCTION CAUSE INCREASED URINARY FREQUENCY?

☐ YES ☐ NO

INDICATE FREQUENCY *(If "Yes," check all that apply)*

☐ DAYTIME VOIDING INTERVAL BETWEEN 2 AND 3 HOURS
☐ DAYTIME VOIDING INTERVAL BETWEEN 1 AND 2 HOURS
☐ DAYTIME VOIDING INTERVAL LESS THAN 1 HOUR
☐ NIGHTTIME AWAKENING TO VOID 2 TIMES
☐ NIGHTTIME AWAKENING TO VOID 3 TO 4 TIMES
☐ NIGHTTIME AWAKENING TO VOID 5 OR MORE TIMES

D. DOES THE VOIDING DYSFUNCTION CAUSE SIGNS OR SYSTEMS OF OBSTRUCTED VOIDING?

☐ YES ☐ NO *(If yes, check all that apply):*

☐ Hesitancy
If checked, is hesitancy marked?
☐ YES ☐ NO

☐ Slow stream
If checked, is stream markedly slow?
☐ YES ☐ NO

☐ Weak stream
If checked, is stream markedly weak?
☐ YES ☐ NO

☐ Decreased force of stream
If checked, is force of stream markedly decreased?
☐ YES ☐ NO

☐ Obstructive symptomatology without stricture disease requiring dilatation one to two times per year
☐ Stricture disease requiring dilatation 1 to 2 times per year
☐ Stricture disease requiring periodic dilatation every 2 to 3 months
☐ Recurrent urinary tract infections secondary to obstruction
☐ Uroflowmetry peak flow rate less than 10 cc/sec
☐ Post void residuals greater than 150 cc
☐ Marked obstructive symptomatology
☐ Urinary retention requiring intermittent catheterization
☐ Urinary retention requiring continuous catheterization
☐ Other, describe: ____________________

SECTION V - URINARY TRACT/KIDNEY INFECTION

5. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT OR KIDNEY INFECTIONS?

☐ YES ☐ NO *(If "Yes," provide etiology)* ____________________

IF THE VETERAN HAS HAD RECURRENT SYMPTOMATIC URINARY TRACT OR KIDNEY INFECTIONS, INDICATE ALL TREATMENT MODALITIES THAT APPLY:

☐ NO TREATMENT

☐ LONG-TERM DRUG THERAPY *(If checked, list medications used and indicate dates for courses of treatment over the past 12 months)*

☐ HOSPITALIZATION *(If checked, indicate frequency of hospitalization)*
☐ 1 OR 2 PER YEAR
☐ > 2 PER YEAR

☐ DRAINAGE *(If checked, indicate dates when drainage performed over past 12 months)*

☐ CONTINUOUS INTENSIVE MANAGEMENT *(If checked, indicate types of treatment and medications used over past 12 months)*

☐ INTERMITTENT INTENSIVE MANAGEMENT *(If checked, indicate types of treatment and medications used over past 12 months)*

☐ OTHER *(Describe)*

SECTION VI - ERECTILE DYSFUNCTION

6A. DOES THE VETERAN HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO *(If "Yes," provide etiology)* ____________________

6B. IF THE VETERAN HAS ERECTILE DYSFUNCTION, IS IT AS LIKELY AS NOT (AT LEAST A 50%PROBABILITY) ATTRIBUTABLE TO ONE OF THE DIAGNOSES IN SECTION I, INCLUDING RESIDUALS OF TREATMENT FOR THIS DIAGNOSIS?

☐ YES ☐ NO

(If "Yes," specify the diagnosis to which the erectile dysfunction is as likely as not attributable) ____________________

6C. IF THE VETERAN HAS ERECTILE DYSFUNCTION, IS HE ABLE TO ACHIEVE AN ERECTION SUFFICIENT FOR PENETRATION AND EJACULATION WITHOUT MEDICATION?

☐ YES ☐ NO

If no, has the Veteran used medications for treatment of his erectile dysfunction?

☐ YES ☐ NO

If yes, is the Veteran able to achieve an erection sufficient for penetration and ejaculation with medication?

☐ YES ☐ NO

SECTION VII - RETROGRADE EJACULATION

7A. DOES THE VETERAN HAVE RETROGRADE EJACULATION?

☐ YES ☐ NO *(If "Yes," provide etiology of the retrograde ejaculation)* ______________________

7B. IF THE VETERAN HAS RETROGRADE EJACULATION, IS IT AS LIKELY AS NOT (AT LEAST A 50%PROBABILITY) ATTRIBUTABLE TO ONE OF THE DIAGNOSES IN SECTION I, INCLUDING RESIDUALS OF TREATMENT FOR THIS DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," specify the diagnosis to which the retrograde ejaculation is as likely as not attributable)* ______________________

SECTION VIII - RESIDUAL CONDITIONS AND/OR COMPLICATIONS

8. DOES THE VETERAN HAVE ANY OTHER RESIDUAL CONDITIONS AND/OR COMPLICATIONS DUE TO PROSTATE CANCER OR TREATMENT FOR PROSTATE CANCER?

☐ YES ☐ NO *(If "Yes," describe):*

SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTIONS

9A. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than or equal to 39 square cm (6 square inches)

☐ YES ☐ NO

(If "Yes," also complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

9B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS?

☐ YES ☐ NO *(If "Yes," describe (brief summary))*

SECTION X - DIAGNOSTIC TESTING

NOTE - If laboratory test results are in the medical record and reflect the veteran's current condition, repeat testing is not required.

10. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO *(If "Yes," provide type of test or procedure, date and results (brief summary))*

SECTION XI - FUNCTIONAL IMPACT

11. DOES THE VETERAN'S PROSTATE CANCER IMPACT HIS ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of the veteran's prostate cancer, providing one or more examples)*

SECTION XII - REMARKS

12. REMARKS *(If any)*

SECTION XIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

13A. PHYSICIAN'S SIGNATURE	13B. PHYSICIAN'S PRINTED NAME	13C. DATE SIGNED

13D. PHYSICIAN'S PHONE AND FAX NUMBER	13E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	13F. PHYSICIAN'S ADDRESS