Department of Veterans Affairs

SLEEP APNEA 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

DOES THE VETERAN HAVE OR HAS HE OR SHE EVER HAD SLEEP APNEA? ☐ YES ☐ NO

NOTE: The diagnosis of sleep apnea must be confirmed by a sleep study; provide sleep study results in Diagnostic testing section. If other respiratory condition is diagnosed, complete the Respiratory and / or Narcolepsy Questionnaire(s), in lieu of this one.

IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SLEEP APNEA AND CHECK DIAGNOSTIC TYPE:

☐ OBSTRUCTIVE	ICD Code: _____	Date of diagnosis: _____
☐ CENTRAL	ICD Code: _____	Date of diagnosis: _____
☐ MIXED, COMPONENTS OF BOTH	ICD Code: _____	Date of diagnosis: _____
☐ OTHER SLEEP DISORDER (specify): _____	ICD Code: _____	Date of diagnosis: _____

IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO A DIAGNOSIS OF SLEEP APNEA, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S SLEEP DISORDER CONDITION (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF A SLEEP DISORDER CONDITION?

☐ YES ☐ NO (If "Yes," list only those medications required for the veteran's sleep disorder condition):

2C. DOES THE VETERAN REQUIRE THE USE OF A BREATHING ASSISTANCE DEVICE SUCH AS A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) MACHINE?

☐ YES ☐ NO

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO SLEEP APNEA?

☐ YES ☐ NO (If, "Yes," check all that apply)

- ☐ Persistent daytime hypersomnolence
- ☐ Carbon dioxide retention
- ☐ Chronic respiratory failure
- ☐ Cor pulmonale
- ☐ Requires tracheostomy
- ☐ Other, describe: _____

SECTION IV - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, DESCRIBE (brief summary):

4B. 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?

☐ 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: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

4C. COMMENTS, IF ANY:

SECTION V - DIAGNOSTIC TESTING

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

5A. HAS A SLEEP STUDY BEEN PERFORMED?

☐ YES ☐ NO

(If, "Yes," does the veteran have documented sleep disorder breathing?)

☐ YES ☐ NO

Date of sleep study: _____

Name of facility where sleep study performed, if known: _____

Results: _____

5B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

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

SECTION VI - FUNCTIONAL IMPACT

6. DOES THE VETERAN'S SLEEP APNEA IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO (If "Yes," describe impact of the veteran's sleep apnea, providing one or more examples):

SECTION VII - REMARKS

7. REMARKS (If any)

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE AND FAX NUMBER	8E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	8F. PHYSICIAN'S ADDRESS