Department of Veterans Affairs

BONES AND OTHER SKELETAL CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:	Claimant/Veteran's Social Security Number:	Date of Examination:

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.

DOMINANT HAND

Dominant hand: ☐ Right ☐ Left ☐ Ambidextrous

SECTION I - DIAGNOSIS

1A. List the claimed conditions that pertain to this questionnaire:

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

☐ The Veteran does not have a current diagnosis associated with any claimed conditions listed above. (Explain your findings and reasons in the remarks section)

	Side affected:			ICD Code:	Date of diagnosis:	
☐ Skull fracture	☐ Right	☐ Left	☐ Both		Right:	Left:
☐ Skull loss	☐ Right	☐ Left	☐ Both		Right:	Left:
☐ Costochondritis	☐ Right	☐ Left	☐ Both		Right:	Left:

SECTION I - DIAGNOSIS (continued)

	Side affected:			ICD Code:	Date of diagnosis:	
☐ Rib fracture	☐ Right	☐ Left	☐ Both		Right:	Left:
☐ Rib resection	☐ Right	☐ Left	☐ Both		Right:	Left:
☐ Bones, neoplasm, malignant primary or secondary	☐ Right	☐ Left	☐ Both		Right:	Left:
☐ Bones, neoplasm, benign	☐ Right	☐ Left	☐ Both		Right:	Left:
☐ Coccyx, removal of					Date:	

☐ Other (specify)

Other diagnosis #1 _____

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #2 _____

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #3 _____

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

If there are additional diagnoses that pertain to the bones or other skeletal conditions, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's bone and/or other skeletal condition (brief summary):

SECTION III - SKULL, LOSS OF PART OF, BOTH INNER AND OUTER TABLES

3A. If skull loss or fracture is present, does the Veteran have a brain hernia? ☐ Yes ☐ No

3B. If skull loss is present, indicate the area of skull loss:

☐ Area smaller than the size of a 25-cent piece or 0.716 in^2 (4.619 cm^2)

☐ Area intermediate

☐ Area larger than size of a 50-cent piece or 1.140 in^2 (7.355 cm^2)

SECTION IV - SPINE AND CHEST

4A. Does the Veteran have costochondritis? ☐ Yes ☐ No If yes, describe below:

4B. Has the Veteran undergone rib removal or resection? ☐ Yes ☐ No If yes, please specify:

☐ Rib removal (complete the following):

- ☐ More than six
- ☐ Five or six
- ☐ Three or four
- ☐ Two
- ☐ One

☐ Resection of two or more ribs without regeneration

4C. Has the Veteran undergone removal of the coccyx? ☐ Yes ☐ No If yes, please specify:

☐ Partial or complete, with painful residuals

☐ Without painful residuals (including no residuals)

SECTION V - TUMORS AND NEOPLASMS

5A. 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, also complete questions 5B through 5E.

5B. Is the neoplasm:

☐ Benign

☐ Malignant (if malignant complete the following):

☐ Primary ☐ Secondary (metastatic) If secondary, indicate the primary site, if known: _____

5C. Indicate the type of treatment the Veteran is currently undergoing or has completed (check all that apply):

☐ Treatment completed; currently in watchful waiting status

☐ Surgery

Date of surgery: _____

Type of surgery and description: _____

☐ 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

Date of most recent procedure: _____

Type of procedure and description: _____

☐ Other therapeutic treatment

Date of most recent treatment: _____

Type of treatment and description: _____

Date of completion of treatment or anticipated date of completion: _____

5D. 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, complications (brief summary), and also complete the appropriate questionnaire:

5E. If there are additional malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the format in 5C:

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

6A. 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):

6B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?
☐ Yes ☐ No If yes, also complete the appropriate dermatological questionnaire.

SECTION VII - ASSISTIVE DEVICES

7A. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible? ☐ Yes ☐ No

If yes, identify the assistive devices used (check all that apply and indicate frequency):

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other, describe: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

7B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

Note: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

8A. Due to the Veteran's bones or other skeletal condition(s), is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis (functions of the upper extremity include grasping, manipulation, etc., while functions of the lower extremity include balance, propulsion, etc.)?

☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.

☐ No

If yes, indicate extremities for which this applies: ☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

8B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

SECTION IX - DIAGNOSTIC TESTING

9A. Have imaging studies been performed in conjunction with this examination? ☐ Yes ☐ No If yes, indicate tests performed, dates, and results:

☐ Bone scan	Date of test: _____	Results: _____
☐ X-ray	Date of test: _____	Results: _____
☐ MRI	Date of test: _____	Results: _____
☐ Bone biopsy and/or culture	Date of test: _____	Results: _____
☐ Other, describe: _____	Date of test: _____	Results: _____

9B. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?
☐ Yes ☐ No If yes, provide type of test or procedure, date, and results (brief summary):

9C. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION X - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

10A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)? ☐ Yes ☐ No If yes, describe the functional impact of each condition, providing one or more examples:

SECTION XI - REMARKS

11A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

12A. Examiner's signature:

12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

12D. Date Signed:

12E. Examiner's phone/fax numbers:

12F. National Provider Identifier (NPI) number:

12G. Medical license number and state:

12H. Examiner's address: