Department of Veterans Affairs

EATING DISORDERS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

IMPORTANT- If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the Veterans Crisis Line at 1-800-273-TALK (8255). Stay on the Crisis Line until help can link the Veteran to emergency care.

NOTE - In order to conduct an INITIAL examination for eating disorders, the examiner must meet one of the following criteria: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

In order to conduct a REVIEW examination for eating disorders, the examiner must meet one of the criteria from above, OR be a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or doctorate-level psychologist.

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

1. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN EATING DISORDER(S)?

☐ YES ☐ NO

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

☐ BULIMIA
DATE OF DIAGNOSIS: _____ ICD CODE: _____
NAME OF DIAGNOSING FACILITY OR CLINICIAN: _____

☐ ANOREXIA
DATE OF DIAGNOSIS: _____ ICD CODE: _____
NAME OF DIAGNOSING FACILITY OR CLINICIAN: _____

☐ OTHER SPECIFIED FEEDING OR EATING DISORDER
DATE OF DIAGNOSIS: _____ ICD CODE: _____
NAME OF DIAGNOSING FACILITY OR CLINICIAN: _____

SECTION II - MEDICAL HISTORY

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

SECTION III - FINDINGS

NOTE - For VA purposes, an incapacitating episode is defined as a period during which bed rest and treatment by a physician are required.

☐ BINGE EATING FOLLOWED BY MEASURES TO PREVENT WEIGHT GAIN

☐ BINGE EATING FOLLOWED BY SELF-INDUCED VOMITING

☐ INCAPACITATING EPISODES OF MORE THAN TWO BUT LESS THAN SIX WEEKS TOTAL DURATION PER YEAR

☐ INCAPACITATING EPISODES OF SIX OR MORE WEEKS TOTAL DURATION PER YEAR

☐ INCAPACITATING EPISODES OF UP TO TWO WEEKS TOTAL DURATION PER YEAR

☐ REQUIRING HOSPITALIZATION MORE THAN TWICE A YEAR FOR PARENTERAL NUTRITION

☐ REQUIRING HOSPITALIZATION MORE THAN TWICE A YEAR FOR TUBE FEEDING

☐ RESISTANCE TO WEIGHT GAIN EVEN WHEN BELOW EXPECTED MINIMUM WEIGHT

☐ SELF-INDUCED WEIGHT LOSS TO LESS THAN 80 PERCENT OF EXPECTED MINIMUM WEIGHT

☐ SELF-INDUCED WEIGHT LOSS TO LESS THAN 85 PERCENT OF EXPECTED MINIMUM WEIGHT

☐ WITHOUT INCAPACITATING EPISODES

SECTION IV - OTHER SYMPTOMS

4. DOES THE VETERAN HAVE ANY OTHER SYMPTOMS ATTRIBUTABLE TO AN EATING DISORDER?

☐ YES ☐ NO (If "Yes," describe):

SECTION V - FUNCTIONAL IMPACT

5. DOES THE VETERAN'S EATING DISORDER(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO (If "Yes," describe impact, providing one or more examples):

SECTION VI - REMARKS

6. REMARKS (If any)

SECTION VII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

7A. Examiner's signature:

7B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

7C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

7D. Date Signed:

7E. Examiner's phone/fax numbers:

7F. National Provider Identifier (NPI) number:

7G. Medical license number and state:

7H. Examiner's address: