Department of Veterans Affairs

GALLBLADDER AND PANCREAS CONDITIONS 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 OR SHE EVER BEEN DIAGNOSED WITH A GALLBLADDER OR PANCREAS CONDITION?

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

1B. SELECT THE VETERAN'S CONDITION *(check all that apply):*

☐ Cholecystitis, chronic ICD Code: ____________ Date of Diagnosis: ____________
☐ Cholelithiasis, chronic ICD Code: ____________ Date of Diagnosis: ____________
☐ Cholangitis, chronic ICD Code: ____________ Date of Diagnosis: ____________
☐ Cholecystectomy *(gallbladder, removal of)* ICD Code: ____________ Date of Diagnosis: ____________
☐ Pancreatitis ICD Code: ____________ Date of Diagnosis: ____________
☐ Total pancreatectomy ICD Code: ____________ Date of Diagnosis: ____________
☐ Partial pancreatectomy ICD Code: ____________ Date of Diagnosis:____________
☐ Gallbladder neoplasm ICD Code: ____________ Date of Diagnosis: ____________
☐ Pancreatic neoplasm ICD Code: ____________ Date of Diagnosis: ____________
☐ Gallbladder or pancreas injury, with peritoneal adhesions resulting from this injury ICD Code: ____________ Date of Diagnosis: ____________

(If checked, ALSO complete the Peritoneal Adhesions Questionnaire)

☐ Other gallbladder conditions:

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 GALLBLADDER OR PANCREAS CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION *(brief summary):*

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

☐ YES ☐ NO *(If "Yes," list only those medications required for the gallbladder or pancreas condition):*

SECTION III - GALLBLADDER CONDITIONS: SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY GALLBLADDER CONDITIONS OR RESIDUALS OF TREATMENT FOR GALLBLADDER CONDITIONS?

☐ YES ☐ NO

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

☐ Gallbladder dyspepsia *confirmed by X-ray*
(If checked, indicate number of episodes per year):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Attacks gallbladder colic
(If checked, indicate number of attacks per year):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Frequent attacks gallbladder colic
☐ Infrequent attacks (not over two or three a year) of gallbladder colic
☐ Mild symptoms ☐ Moderate symptoms ☐ Severe symptoms
☐ Cholecystectomy post operative residuals:
☐ Asymptomatic ☐ Mild symptoms ☐ Severe symptoms
☐ Jaundice
(If checked, provide bilirubin level in Diagnostic Testing section)
☐ Other signs or symptoms, describe: ____________

SECTION IV - PANCREAS CONDITIONS: SIGNS AND SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SYMPTOMS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

☐ YES ☐ NO

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

☐ Abdominal pain, confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies

(If checked, indicate severity and frequency of attacks, check all that apply):

☐ Mild (typical) ☐ Moderately Severe ☐ Severe (disabling)

(Indicate number of attacks of MILD (TYPICAL) abdominal pain in the past 12 months):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

(Indicate number of attacks of MODERATELY SEVERE abdominal pain in the past 12 months):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

(Indicate number of attacks of SEVERE (DISABLING) abdominal pain in the past 12 months):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

☐ Remissions/pain-free intermissions between attacks

(If checked, indicate characteristics of remissions):

☐ Good pain-free remissions between attacks

☐ Few pain-free intermissions between attacks

☐ Other findings showing continuing pancreatic insufficiency between attacks

☐ Other symptoms, describe: ______________________________

4B. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR FINDINGS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

☐ YES ☐ NO

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

☐ Steatorrhea

(If checked, describe frequency and severity): ______________________________

☐ Malabsorption

(If checked, describe frequency and severity): ______________________________

☐ Diarrhea

(If checked, describe frequency and severity): ______________________________

☐ Severe malnutrition

(If checked, describe deficiency (such as beta-carotene, fat-soluble vitamin deficiencies)): ______________________________

☐ Loss of normal body weight

(If checked, provide baseline weight: ______________ *and current weight:* ______________ *).*

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

☐ Other, describe: ______________________________

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

5A. 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*):

5B. 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.

5C. COMMENTS, IF ANY:

SECTION VI - DIAGNOSTIC TESTING

NOTE: Diagnosis of pancreatitis must be confirmed by appropriate laboratory and clinical studies. If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

6A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

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

☐ EUS *(Endoscopic ultrasound)* Date: __________ Results: __________

☐ ERCP *(Endoscopic retrograde cholangiopancreatography)* Date: __________ Results: __________

☐ Transhepatic cholangiogram Date: __________ Results: __________

☐ MRI or MRCP *(magnetic resonance cholangiopancreatography)* Date: __________ Results: __________

☐ Gallbladder scan *(HIDA scan or cholescintigraphy)* Date: __________ Results: __________

☐ CT Date: __________ Results: __________

☐ Other, specify: __________ Date: __________ Results: __________

6B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

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

☐ Alkaline phosphatase Date: __________ Results: __________

☐ Bilirubin Date: __________ Results: __________

☐ WBC Date: __________ Results: __________

☐ Amylase Date: __________ Results: __________

☐ Lipase Date: __________ Results: __________

☐ Other, specify: __________ Date: __________ Results: __________

6C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

(If "Yes," provide type of test or procedure, date and results in a brief summary):

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION(S) IMPACT ON HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the Veteran's gallbladder and/or pancreas conditions, providing one or more examples):*

SECTION VIII - REMARKS

8. REMARKS *(If any)*

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. Examiner's signature:

9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

9D. Date Signed:

9E. Examiner's phone/fax numbers:

9F. National Provider Identifier (NPI) number:

9G. Medical license number and state:

9H. Examiner's address: