Department of Veterans Affairs

INFECTIOUS INTESTINAL DISORDERS, INCLUDING BACTERIAL AND PARASITIC INFECTIONS 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 AN INFECTIOUS INTESTINAL CONDITION?

☐ YES ☐ NO

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

☐ BACILLARY DYSENTERY ICD code: _____ Date of diagnosis: _____

☐ INTESTINAL DISTOMIASIS *(intestinal fluke)* ICD code: _____ Date of diagnosis: _____

☐ PARASITIC INFECTION OF THE INTESTINES ICD code: _____ Date of diagnosis: _____

☐ AMEBIASIS ICD code: _____ Date of diagnosis: _____

NOTE: If the Veteran has a lung abscess due to amebiasis, ALSO complete the Respiratory Questionnaire.

☐ OTHER INFECTIOUS INTESTINAL CONDITION

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 INFECTIOUS INTESTINAL CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset, course, and past treatment)* OF THE VETERAN'S INFECTIOUS INTESTINAL CONDITIONS *(brief summary)*:

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S INTESTINAL CONDITIONS?

☐ YES ☐ NO IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR THE INTESTINAL CONDITIONS:

2C. HAS THE VETERAN HAD SURGICAL TREATMENT FOR AN INTESTINAL CONDITION?

☐ YES ☐ NO *(If "Yes," ALSO complete the Intestinal Surgery Questionnaire)*

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY INFECTIOUS INTESTINAL CONDITIONS?

☐ YES ☐ NO IF YES, CHECK ALL THAT APPLY

☐ MILD SYMPTOMS ATTRIBUTABLE TO DISTOMIASIS, INTESTINAL OR HEPATIC *(If checked, describe)*: _____

☐ MODERATE SYMPTOMS ATTRIBUTABLE TO DISTOMIASIS, INTESTINAL OR HEPATIC *(If checked, describe)*: _____

☐ SEVERE SYMPTOMS ATTRIBUTABLE TO DISTOMIASIS, INTESTINAL OR HEPATIC *(If checked, describe)*: _____

☐ MILD GASTROINTESTINAL DISTURBANCES *(If checked, describe)*: _____

☐ LOWER ABDOMINAL CRAMPS. *If checked, describe*: _____

☐ GASEOUS DISTENTION *(If checked, describe)*: _____

☐ CHRONIC CONSTIPATION INTERRUPTED BY DIARRHEA *(If checked, describe)*: _____

☐ ANEMIA (If checked, provide hemoglobin/hematocrit in Section 8, Diagnostic Testing)

☐ NAUSEA *(If checked, describe)*: _____

☐ VOMITING *(If checked, describe)*: _____

☐ OTHER, *(describe)*: _____

NOTE - Complete the appropriate Disability Questionnaire(s) when the infectious disease affects other organs such as the liver, lung, kidney, etc. (schedule with appropriate provider).

SECTION IV - SYMPTOM EPISODES, ATTACKS AND EXACERBATIONS

4. DOES THE VETERAN HAVE EPISODES OF BOWEL DISTURBANCE WITH ABDOMINAL DISTRESS, OR EXACERBATIONS OR ATTACKS OF THE INTESTINAL CONDITION?

☐ YES ☐ NO IF YES, INDICATE SEVERITY AND FREQUENCY*(check all that apply)*

☐ EPISODES OF BOWEL DISTURBANCE WITH ABDOMINAL DISTRESS. IF CHECKED, INDICATE FREQUENCY:

- ☐ Occasional episodes
- ☐ Frequent episodes
- ☐ More or less constant abdominal distress

☐ EPISODES OF EXACERBATIONS AND/OR ATTACKS OF THE INTESTINAL CONDITION
IF CHECKED, DESCRIBE TYPICAL EXACERBATION OR ATTACK: _____

INDICATE NUMBER OF EXACERBATIONS AND/OR ATTACKS IN PAST 12 MONTHS:

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

SECTION V - WEIGHT LOSS

5. DOES THE VETERAN HAVE WEIGHT LOSS ATTRIBUTABLE TO AN INFECTIOUS INTESTINAL CONDITION?

☐ YES ☐ NO

IF YES, PROVIDE VETERAN'S BASELINE WEIGHT: _____ AND CURRENT WEIGHT: _____

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

SECTION VI - MALNUTRITION, COMPLICATIONS AND OTHER GENERAL HEALTH EFFECTS

6. DOES THE VETERAN HAVE MALNUTRITION, SERIOUS COMPLICATIONS OR OTHER GENERAL HEALTH EFFECTS ATTRIBUTABLE TO THE INTESTINAL CONDITION?

☐ YES ☐ NO IF YES, INDICATE SEVERITY*(check all that apply)*

- ☐ Health only fair during remissions
- ☐ Resulting in general debility
- ☐ Resulting in serious complication such as liver abscess
- ☐ Malnutrition. If checked, is malnutrition marked? ☐ Yes ☐ No
- ☐ Other, describe: _____

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

7A. 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*):

7B. 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.

7C. COMMENTS, IF ANY:

SECTION VIII - DIAGNOSTIC TESTING

NOTE: If imaging studies, diagnostic procedures or laboratory testing have been performed and reflect the Veteran's current condition, provide most recent results; no further studies or testing are required for this examination.

8A. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ CBC *(if anemia due to any intestinal condition is suspected or present)*

Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

☐ Other, specify: _____

Date of test: _____

Results: _____

8B. HAVE IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

8C. 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 IX - FUNCTIONAL IMPACT

9. DO ANY OF THE VETERAN'S INFECTIOUS INTESTINAL CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S INFECTIOUS INTESTINAL CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION X - REMARKS

10. REMARKS, IF ANY:

SECTION IX - EXAMINER'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: