Department of Veterans Affairs

INTESTINAL CONDITIONS (OTHER THAN SURGICAL OR INFECTIOUS) (INCLUDING IRRITABLE BOWEL SYNDROME, CROHN'S DISEASE, ULCERATIVE COLITIS, AND DIVERTICULITIS) 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 INTESTINAL CONDITION (other than surgical or infectious)?

☐ YES ☐ NO If "Yes," complete Item 1B

1B. SELECT THE VETERAN'S CONDITION (Check all that apply)

☐	IRRITABLE BOWEL SYNDROME	ICD code:		Date of diagnosis:
☐	SPASTIC COLITIS	ICD code:		Date of diagnosis:
☐	MUCOUS COLITIS	ICD code:		Date of diagnosis:
☐	CHRONIC DIARRHEA	ICD code:		Date of diagnosis:
☐	ULCERATIVE COLITIS	ICD code:		Date of diagnosis:
☐	CROHN'S DISEASE	ICD code:		Date of diagnosis:
☐	CHRONIC ENTERITIS	ICD code:		Date of diagnosis:
☐	CHRONIC ENTEROCOLITIS	ICD code:		Date of diagnosis:
☐	CELIAC DISEASE	ICD code:		Date of diagnosis:
☐	DIVERTICULITIS	ICD code:		Date of diagnosis:
☐	INTESTINAL NEOPLASM	ICD code:		Date of diagnosis:
☐	PERITONEAL ADHESIONS ATTRIBUTABLE TO DIVERTICULITIS. IF CHECKED, ALSO COMPLETE Peritoneal Adhesions Questionnaire	ICD code:		Date of diagnosis:

☐ OTHER NON-SURGICAL OR NON-INFECTIOUS INTESTINAL 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 INTESTINAL CONDITIONS (other than surgical or infectious), LIST USING THE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S INTESTINAL CONDITION (Brief summary)

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

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR THE INTESTINAL CONDITION

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 NON-SURGICAL NON-INFECTIOUS INTESTINAL CONDITIONS?

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

☐ DIARRHEA (If checked, describe)

_____

☐ ALTERNATING DIARRHEA AND CONSTIPATION (If checked, describe)

_____

☐ ABDOMINAL DISTENSION (If checked, describe)

_____

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

☐ NAUSEA (If checked, describe)

_____

☐ VOMITING (If checked, describe)

_____

☐ OTHER (If checked, describe)

_____

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 INTESTINAL CONDITION (other than surgical or infectious condition)?

☐ YES ☐ NO

If "Yes," provide Veteran's baseline weight: _____ and current weight: _____

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 findings) (Check all that apply

- ☐ Health only fair during remissions
- ☐ General debility
- ☐ Serious complication such as liver abscess (Describe)

- ☐ Malnutrition. If checked, is malnutrition marked? ☐ YES ☐ NO
- ☐ Other (Describe)

NOTE: Complete additional Disability Benefits Questionnaire(s) for complications noted, as deemed appropriate (schedule with appropriate provider).

SECTION VII - TUMORS AND NEOPLASMS

7A. 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," complete the following:

7B. IS THE NEOPLASM

☐ BENIGN ☐ MALIGNANT

7C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

☐ YES ☐ NO, WATCHFUL WAITING

IF YES, INDICATE TYPE OF TREATMENT THE VETERAN IS CURRENTLY UNDERGOING OR HAS COMPLETED (Check all that apply)

☐ Treatment completed, currently in watchful waiting status

☐ Surgery (If checked, describe) _____

Date(s) of surgery: _____

☐ 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 (If checked, describe procedure)

_____

Date of most recent procedure: _____

☐ Other therapeutic treatment (If checked, describe treatment)

_____

Date of completion of treatment or anticipated date of completion _____

7D. 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 AND COMPLICATIONS (Brief summary)

7E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

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

8A. 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):

SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS (continued)

8B. 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.

8C. COMMENTS, IF ANY:

SECTION IX - DIAGNOSTIC TESTING

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

9A. 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: _____

9B. 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)

9C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO IF YES, DESCRIBE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (Brief summary)

SECTION X - FUNCTIONAL IMPACT

10. DOES THE VETERAN'S INTESTINAL CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S INTESTINAL CONDITIONS, PROVIDING ONE OR MORE EXAMPLES

SECTION XI - REMARKS

11. REMARKS (If any)

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: