



HEPATITIS, CIRRHOSIS AND OTHER LIVER 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 LIVER CONDITION?

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

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

- | | | | |
|---|-----------------|--------------------------|------------------------|
| <input type="checkbox"/> Hepatitis A | ICD code: _____ | Date of diagnosis: _____ | (complete Section III) |
| <input type="checkbox"/> Hepatitis B | ICD code: _____ | Date of diagnosis: _____ | (complete Section III) |
| <input type="checkbox"/> Hepatitis C | ICD code: _____ | Date of diagnosis: _____ | (complete Section III) |
| <input type="checkbox"/> Autoimmune hepatitis | ICD code: _____ | Date of diagnosis: _____ | (complete Section III) |
| <input type="checkbox"/> Drug-induced hepatitis | ICD code: _____ | Date of diagnosis: _____ | (complete Section III) |
| <input type="checkbox"/> Hemochromatosis | ICD code: _____ | Date of diagnosis: _____ | (complete Section III) |
| <input type="checkbox"/> Cirrhosis of the liver | ICD code: _____ | Date of diagnosis: _____ | (complete Section IV) |
| <input type="checkbox"/> Primary biliary cirrhosis | ICD code: _____ | Date of diagnosis: _____ | (complete Section IV) |
| <input type="checkbox"/> Sclerosing cholangitis | ICD code: _____ | Date of diagnosis: _____ | (complete Section IV) |
| <input type="checkbox"/> Liver transplant candidate | ICD code: _____ | Date of diagnosis: _____ | (complete Section V) |
| <input type="checkbox"/> Liver transplant | ICD code: _____ | Date of diagnosis: _____ | (complete Section V) |
| <input type="checkbox"/> Other liver 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 LIVER CONDITIONS, LIST USING ABOVE FORMAT:

NOTE: Determination of these conditions requires documentation by appropriate serologic testing, abnormal liver function tests, and/or abnormal liver biopsy or imaging tests. If test results are documented in the medical record, additional testing is not required.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (*including cause, onset and course*) OF THE VETERAN'S LIVER CONDITIONS (*brief summary*):

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

YES NO

IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR THE LIVER CONDITIONS:

SECTION III - HEPATITIS

(Including hepatitis A, B and C, autoimmune or drug-induced hepatitis, any other infectious liver disease and chronic liver disease without cirrhosis)

3A. DOES THE VETERAN CURRENTLY HAVE SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC OR INFECTIOUS LIVER DISEASES?

YES NO

IF YES, INDICATE SIGNS AND SYMPTOMS ATTRIBUTABLE TO CHRONIC OR INFECTIOUS LIVER DISEASES *(check all that apply)*:

Fatigue

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Malaise

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Anorexia

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Nausea

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Vomiting

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Arthralgia

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Weight loss

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)

Also, indicate if this weight loss has been sustained for three months or longer: YES NO

Right upper quadrant pain

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Hepatomegaly

Condition requires dietary restriction

If checked, describe dietary restrictions: _____

Condition results in other indications of malnutrition

If checked, describe other indications of malnutrition: _____

Other, describe: _____

3B. HAS THE VETERAN BEEN DIAGNOSED WITH HEPATITIS C?

YES NO

IF YES, INDICATE RISK FACTORS *(check all that apply)*:

Unknown

No known risk factors

Organ transplant before 1992

Transfusions of blood or blood products before 1992

Hemodialysis

Accidental exposure to blood by health care workers *(to include combat medic or corpsman)*

Intravenous drug use or intranasal cocaine use

High risk sexual activity

Other direct percutaneous exposure to blood *(such as by tattooing, body piercing, acupuncture with non-sterile needles, shared toothbrushes and/or shaving razors)*

If checked, describe: _____

Other, describe: _____

3C. HAS THE VETERAN HAD ANY INCAPACITATING EPISODES *(with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)* DUE TO THE LIVER CONDITIONS DURING THE PAST 12 MONTHS?

YES NO

IF YES, PROVIDE THE TOTAL DURATION OF THE INCAPACITATING EPISODES OVER THE PAST 12 MONTHS:

Less than 1 week

At least 1 week but less than 2 weeks

At least 2 weeks but less than 4 weeks

At least 4 weeks but less than 6 weeks

6 weeks or more

NOTE: For VA purposes, an "incapacitating episode" means a period of acute symptoms severe enough to require bed rest and treatment by a physician.

SECTION IV - CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS AND CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS

4A. DOES THE VETERAN CURRENTLY HAVE SIGNS OR SYMPTOMS ATTRIBUTABLE TO CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS OR CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS?

YES NO

IF YES, INDICATE SIGNS AND SYMPTOMS ATTRIBUTABLE TO CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS OR CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS (*check all that apply*):

Weakness

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Anorexia

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Abdominal pain

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Malaise

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Weight loss

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)

Also, indicate if this weight loss has been sustained for three months or longer: YES NO

Ascites

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

1 episode 2 or more episodes Periods of remission between attacks Refractory to treatment

Date of last episode of ascites: _____

Hepatic encephalopathy

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

1 episode 2 or more episodes Periods of remission between attacks Refractory to treatment

Date of last episode of hepatic encephalopathy: _____

Hemorrhage from varices or portal gastropathy (*erosive gastritis*)

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

1 episode 2 or more episodes Periods of remission between attacks Refractory to treatment

Date of last episode of hemorrhage from varices or portal gastropathy: _____

Portal hypertension

Splenomegaly

Persistent jaundice

SECTION V - LIVER TRANSPLANT AND/OR LIVER INJURY

5A. IS THE VETERAN A LIVER TRANSPLANT CANDIDATE?

YES NO

5B. IS THE VETERAN CURRENTLY HOSPITALIZED AWAITING TRANSPLANT?

YES NO

Date of hospital admission for this condition: _____

5C. HAS THE VETERAN UNDERGONE A LIVER TRANSPLANT?

YES NO

Date(s) of surgery: _____

Date of hospital discharge: _____

Current signs and symptoms: _____

5D. HAS THE VETERAN HAD AN INJURY TO THE LIVER?

YES NO

IF YES, DOES THE VETERAN HAVE PERITONEAL ADHESIONS RESULTING FROM AN INJURY TO THE LIVER?

YES NO

(If "Yes," ALSO complete the Peritoneal Adhesions Questionnaire)

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 THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO

IF YES, DESCRIBE (*brief summary*):

SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS (Continued)

6B. 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.

6C. COMMENTS, IF ANY:

SECTION VII - DIAGNOSTIC TESTING

NOTE: Diagnosis of hepatitis C must be confirmed by recombinant immunoblot assay (RIBA). If this information is of record, repeat RIBA test is not required. If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

7A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES NO

IF YES, CHECK ALL THAT APPLY:

<input type="checkbox"/> EUS (<i>Endoscopic ultrasound</i>)	Date: _____	Results: _____
<input type="checkbox"/> ERCP (<i>Endoscopic retrograde cholangiopancreatography</i>)	Date: _____	Results: _____
<input type="checkbox"/> Transhepatic cholangiogram	Date: _____	Results: _____
<input type="checkbox"/> MRI or MRCP (<i>magnetic resonance cholangiopancreatography</i>)	Date: _____	Results: _____
<input type="checkbox"/> CT	Date: _____	Results: _____
<input type="checkbox"/> Other, describe: _____	Date: _____	Results: _____

7B. HAVE LABORATORY STUDIES BEEN PERFORMED?

YES NO

IF YES, CHECK ALL THAT APPLY:

<input type="checkbox"/> Recombinant immunoblot assay (<i>RIBA</i>)	Date: _____	Results: _____
<input type="checkbox"/> Hepatitis C genotype	Date: _____	Results: _____
<input type="checkbox"/> Hepatitis C viral titers	Date: _____	Results: _____
<input type="checkbox"/> AST	Date: _____	Results: _____
<input type="checkbox"/> ALT	Date: _____	Results: _____
<input type="checkbox"/> Alkaline phosphatase	Date: _____	Results: _____
<input type="checkbox"/> Bilirubin	Date: _____	Results: _____
<input type="checkbox"/> INR (PT)	Date: _____	Results: _____
<input type="checkbox"/> Creatinine	Date: _____	Results: _____
<input type="checkbox"/> MELD score	Date: _____	Results: _____
<input type="checkbox"/> Other, describe: _____	Date: _____	Results: _____

7C. HAS A LIVER BIOPSY BEEN PERFORMED?

YES NO Date of test: _____ Results: _____

7D. 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 VIII - FUNCTIONAL IMPACT

8. DOES THE VETERAN'S LIVER CONDITION IMPACT HIS OR HER ABILITY TO WORK?

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

SECTION IX - REMARKS

9. REMARKS *(If any)*

SECTION X - EXAMINER'S CERTIFICATION AND SIGNATURE

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

10A. Examiners signature:

10B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

10C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

10D. Date Signed:

10E. Examiner's phone/fax numbers:

10F. National Provider Identifier (NPI) number:

10G. Medical license number and state:

10H. Examiner's address: