

NAME OF CLAIMANT/VETERAN

CLAIMANT/VETERAN'S SOCIAL SECURITY NUMBER

DATE OF EXAMINATION

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.

DOMINANT HAND

Right Left Ambidextrous

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN CURRENTLY HAVE OR HAS PREVIOUSLY HAD A DIAGNOSIS OF OSTEOMYELITIS?

Yes No

1B. IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO OSTEOMYELITIS

Diagnosis # 1 -	ICD Code -	Date of diagnosis
Diagnosis # 2 -	ICD Code -	Date of diagnosis
Diagnosis # 3 -	ICD Code -	Date of diagnosis

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO OSTEOMYELITIS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S OSTEOMYELITIS (BRIEF SUMMARY):

2B. INDICATE LOCATION OF INITIAL INFECTION (CHECK ALL THAT APPLY):

- Pelvis
- Cervical vertebrae
- Thoracolumbar vertebrae
- Long bones of upper extremity Side affected: Right Left
- Long bones of lower extremity Side affected: Right Left
- Finger(s): Right digit(s) affected: _____ Left digit(s) affected: _____
- Toe(s): Right digit(s) affected: _____ Left digit(s) affected: _____
- Other, specify: _____
- Extension into joints (If checked, indicate joints affected):
Right: Shoulder Elbow Wrist Hip Knee Ankle Left: Shoulder Elbow Wrist Hip Knee Ankle
 Hand joint(s) Foot joint(s) Hand joint(s) Foot joint(s)
- Other, specify: _____

2C. HAS THE VETERAN HAD MEDICAL TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING MEDICAL TREATMENT FOR OSTEOMYELITIS?

- Yes No
- (If yes, describe treatment): _____
- Date treatment started: _____
- Date treatment completed or anticipated date of completion: _____

2D. HAS THE VETERAN HAD SURGICAL TREATMENT FOR OSTEOMYELITIS?

- Yes No
- (If yes, indicate surgical procedure and date (if multiple procedures, indicate below)):
- Procedure #1: _____
- Date: _____ Facility: _____
- Procedure #2: _____
- Date: _____ Facility: _____
- If additional surgical procedures, list using above format:

2E. PROVIDE STATUS OF THE VETERAN'S CURRENT OSTEOMYELITIS CONDITION:

- Active (acute, subacute, chronic) Inactive Resolved Other, describe: _____

SECTION III - RECURRENT INFECTIONS

3A. HAS THE VETERAN HAD ANY ADDITIONAL EPISODES OR RECURRING INFECTIONS OF OSTEOMYELITIS FOLLOWING THE INITIAL INFECTION?

- Yes No
- (If "Yes," indicate number of additional episodes):
- 1 2 3 4 5 or more

SECTION III - RECURRENT INFECTIONS (Continued)

3B. LOCATION OF RECURRENT INFECTIONS (CHECK ALL THAT APPLY):

- Pelvis
- Cervical vertebrae
- Thoracolumbar vertebrae
- Long bones of upper extremity Side affected: Right Left
- Long bones of lower extremity Side affected: Right Left
- Finger(s): Right digit(s) affected: _____ Left digit(s) affected: _____
- Toe(s): Right digit(s) affected: _____ Left digit(s) affected: _____
- Other, specify: _____
- Extension into joints
(If checked, indicate joints affected):
 - Right: Shoulder Elbow Wrist Hip Knee Ankle
 - Hand joint(s) Foot joint(s)
 - Left: Shoulder Elbow Wrist Hip Knee Ankle
 - Hand joint(s) Foot joint(s)
- Other, specify: _____

3C. DATES OF RECURRENT INFECTION

Indicate dates of recurrences:

- Date of recurrence #1: _____ Site of recurrent infection: _____
- Date of recurrence #2: _____ Site of recurrent infection: _____
- Date of recurrence #3: _____ Site of recurrent infection: _____

If there are additional recurrences, list using above format: _____

SECTION IV - SIGNS, SYMPTOMS AND FINDINGS

4A. DOES THE VETERAN CURRENTLY HAVE ANY SIGNS OR FINDINGS ATTRIBUTABLE TO OSTEOMYELITIS OR TREATMENT FOR OSTEOMYELITIS?

- Yes No (If yes, check all that apply):
- Involucrum
- Sequestrum
- Discharging sinus
- Amyloidosis secondary to chronic infection
- Anemia (If checked, provide CBC results in diagnostic testing section)
- Other constitutional symptoms (If checked, are the constitutional symptoms continuous?) Yes No
- Decreased joint function or range of motion due to osteomyelitis or residuals of treatment (If checked, indicate affected joints and ALSO complete appropriate Questionnaire for each affected joint and/or spinal segment)
 - Right: Shoulder Elbow Wrist Hip Knee Ankle Single foot joint
 - Hand joint(s) Foot joint(s) Single hand joint
 - Left: Shoulder Elbow Wrist Hip Knee Ankle Single foot joint
 - Hand joint(s) Foot joint(s) Single hand joint
- Cervical vertebral joint(s) Thoracolumbar vertebral joint(s) Specific vertebral joint(s) affected _____

4B. DOES THE VETERAN CURRENTLY HAVE ANY SYMPTOMS ATTRIBUTABLE TO OSTEOMYELITIS OR TREATMENT FOR OSTEOMYELITIS?

- Yes No (If yes, check all that apply):
- Pain (If checked, describe): _____
- Swelling (If checked, describe): _____
- Tenderness (If checked, describe): _____
- Erythema (If checked, describe): _____
- Warmth (If checked, describe): _____
- Malaise (If checked, describe): _____
- Other symptoms, describe: _____

SECTION V - AMPUTATION

5A. HAS THE VETERAN HAD AN AMPUTATION DUE TO OSTEOMYELITIS?

Yes No (If yes, also complete Amputation Questionnaire)

SECTION VI - ASSISTIVE DEVICES

6A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

Yes No

(If yes, identify assistive devices used (check all that apply and indicate frequency)):

- Wheelchair Frequency of use: Occasional Regular Constant
- Brace(s) Frequency of use: Occasional Regular Constant
- Crutch(es) Frequency of use: Occasional Regular Constant
- Cane(s) Frequency of use: Occasional Regular Constant
- Walker Frequency of use: Occasional Regular Constant
- Other: Frequency of use: Occasional Regular Constant

6B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION.

SECTION VII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

7A. DUE TO THE VETERAN'S OSTEOMYELITIS OR RESIDUALS OF TREATMENTS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTION REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? (FUNCTIONS OF THE UPPER EXTREMITY INCLUDE GRASPING, MANIPULATION, ETC., WHILE FUNCTIONS FOR THE LOWER EXTREMITY INCLUDE BALANCE AND PROPULSION, ETC.)

Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran
 No

(If yes, indicate extremities for which this applies):

Right upper Left upper Right lower Left lower

For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary)

Note: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

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

8A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

Yes No (If yes, describe (brief summary)):

SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS (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?

Yes No

(If yes, also complete appropriate dermatological DBQ).

8C. COMMENTS, IF ANY:

SECTION IX - DIAGNOSTIC TESTING

9A. HAVE IMAGING OR LABORATORY STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

Yes No (If yes, indicate tests performed, dates and results):

<input type="checkbox"/> Bone scan	Date of test: _____	Results: _____
<input type="checkbox"/> X-ray	Date of test: _____	Results: _____
<input type="checkbox"/> MRI	Date of test: _____	Results: _____
<input type="checkbox"/> Complete blood count (CBC)	Date of test: _____	Results: _____
<input type="checkbox"/> C-reactive protein (CRP)	Date of test: _____	Results: _____
<input type="checkbox"/> Erythrocyte sedimentation rate (ESR)	Date of test: _____	Results: _____
<input type="checkbox"/> Blood culture	Date of test: _____	Results: _____
<input type="checkbox"/> Bone biopsy and culture	Date of test: _____	Results: _____
<input type="checkbox"/> Other, describe:	Date of test: _____	Results: _____

9B. 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 X - FUNCTIONAL IMPACT

10A. DOES THE VETERAN'S OSTEOMYELITIS IMPACT HIS OR HER ABILITY TO WORK?

Yes No (If yes, describe the impact of the Veteran's osteomyelitis or residuals of treatment, providing one or more examples):

SECTION XI - REMARKS

11A. 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: