

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
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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 HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A SEIZURE DISORDER (epilepsy)? (This is the condition the Veteran is claiming or for which an exam has been requested)

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

SECTION I - DIAGNOSIS (Continued)

1B. SELECT THE APPROPRIATE DIAGNOSIS: (check all that apply):

- | | | |
|---|-----------------|--------------------------|
| <input type="checkbox"/> TONIC-CLONIC SEIZURES OR GRAND MAL EPILEPSY (generalized convulsive seizures) | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> ABSENCE SEIZURES OR PETIT MAL OR ATONIC SEIZURES (generalized non-convulsive seizures) | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> JACKSONIAN (simple partial seizures) | | |
| <input type="checkbox"/> FOCAL MOTOR | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> FOCAL SENSORY | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> DIENCEPHALIC EPILEPSY | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> PSYCHOMOTOR EPILEPSY (complex partial seizures, temporal lobe seizures) | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> OTHER (specify): | | |
| 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 SEIZURE DISORDERS (epilepsy), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S SEIZURE DISORDER (epilepsy) (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF EPILEPSY OR SEIZURE ACTIVITY?
 YES NO (If "Yes," list only those medications required for the Veteran's epilepsy or seizure activity)

2C. HAS THE VETERAN HAD ANY OTHER TREATMENT (such as surgery) FOR EPILEPSY OR SEIZURE ACTIVITY?
 YES NO (If "Yes," describe):

2D. HAS THE DIAGNOSIS OF A SEIZURE DISORDER BEEN CONFIRMED?
 YES NO (If "Yes," describe):

2E. HAS THE VETERAN HAD A WITNESSED SEIZURE?
 YES NO (If "Yes," describe, including relationship of witnesses to Veteran):

2F. HAS THE VETERAN HAD A CONFIRMED DIAGNOSIS OF EPILEPSY WITH A HISTORY OF SEIZURES?
 YES NO

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE OR HAS HE OR SHE HAD ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO SEIZURE DISORDER (epilepsy) ACTIVITY?

- YES NO (If "Yes," check all that apply)
- | | |
|--|--|
| <input type="checkbox"/> Generalized tonic-clonic convulsion | <input type="checkbox"/> Episodes of hallucinations |
| <input type="checkbox"/> Episodes of unconsciousness | <input type="checkbox"/> Episodes of perceptual illusions |
| <input type="checkbox"/> Brief interruption in consciousness or conscious control | <input type="checkbox"/> Episodes of abnormalities of thinking |
| <input type="checkbox"/> Episodes of staring | <input type="checkbox"/> Episodes of abnormalities of memory |
| <input type="checkbox"/> Episodes of rhythmic blinking of the eyes | <input type="checkbox"/> Episodes of abnormalities of mood |
| <input type="checkbox"/> Episodes of nodding of the head | <input type="checkbox"/> Episodes of autonomic disturbances |
| <input type="checkbox"/> Episodes of sudden jerking movement of the arms, trunk or head (myoclonic type) | <input type="checkbox"/> Episodes of speech disturbances |
| <input type="checkbox"/> Episodes of sudden loss of postural control (akinetic type) | <input type="checkbox"/> Episodes of impairment of vision |
| <input type="checkbox"/> Episodes of complete or partial loss of use of one or more extremities | <input type="checkbox"/> Episodes of disturbances of gait |
| <input type="checkbox"/> Episodes of random motor movements | <input type="checkbox"/> Episodes of tremors |
| <input type="checkbox"/> Episodes of psychotic manifestations | <input type="checkbox"/> Episodes of visceral manifestations |
| <input type="checkbox"/> Other | <input type="checkbox"/> Residuals of Injury during seizure |

(For all checked conditions describe):

SECTION IV - TYPE AND FREQUENCY OF SEIZURE ACTIVITY

4A. DOES THE VETERAN HAVE OR HAS HE OR SHE EVER HAD ANY TYPE OF SEIZURE ACTIVITY, INCLUDING MAJOR, MINOR, PETIT MAL OR PSYCHOMOTOR SEIZURE ACTIVITY?

YES NO (If "Yes," complete the following section:)

4B. PROVIDE APPROXIMATE DATE OF FIRST SEIZURE ACTIVITY (Month, Year) _____

PROVIDE DATE OF MOST RECENT SEIZURE ACTIVITY (Month, Year) _____

4C. HAS THE VETERAN EVER HAD MINOR SEIZURES (characterized by a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ("pure" petit mal) or sudden jerking movements of the arms, trunk or head (myoclonic type) or sudden loss of postural control (akinetic type))?

YES NO (If "Yes," complete the following):

Number of minor seizures over past 6 months:

0-1

2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor seizures:

0-4 per week

5-8 per week

9-10 per week

More than 10 per week

4D. HAS THE VETERAN EVER HAD MAJOR SEIZURES (characterized by the generalized tonic-clonic convulsion with unconsciousness)?

YES NO (If "Yes," complete the following):

Number of major seizures:

None in past 2 years

At least 1 in past 2 years

At least 2 in past year

Average frequency of major seizures:

Less than 1 in past 6 months

At least 1 in past 6 months

At least 1 in 4 months over past year

At least 1 in 3 months over past year

At least 1 per month over past year

4E. HAS THE VETERAN EVER HAD MINOR PSYCHOMOTOR SEIZURES (characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances)?

YES NO (If "Yes," complete the following):

Number of minor seizures over past 6 months:

0-1

2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor seizures:

0-4 per week

5-8 per week

9-10 per week

More than 10 per week

4F. HAS THE VETERAN EVER HAD MAJOR PSYCHOMOTOR SEIZURES (major psychomotor seizures are characterized by automatic states and/or generalized convulsions with unconsciousness)?

YES NO (If "Yes," complete the following):

Number of major psychomotor seizures:

None in past 2 years

At least 1 in past 2 years

At least 2 in past year

Average frequency of major psychomotor seizures:

Less than 1 in past 6 months

At least 1 in past 6 months

At least 1 in 4 months over past year

At least 1 in 3 months over past year

At least 1 per month over past year

4G. HAS THE VETERAN EVER HAD EPILEPSY ASSOCIATED WITH A NONPSYCHOTIC ORGANIC BRAIN SYNDROME?

YES NO (If "Yes," describe):

4H. HAS THE VETERAN EVER HAD EPILEPSY ASSOCIATED WITH A PSYCHOTIC DISORDER, PSYCHONEUROTIC DISORDER OR PERSONALITY DISORDER?

YES NO (If "Yes," the appropriate Mental Disorder Questionnaire must ALSO be completed)

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

5A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

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?

YES NO

IF "YES," ARE ANY OF THESE SCARS PAINFUL AND/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 DISABILITY BENEFITS QUESTIONNAIRE (DBQ).

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 the "Remarks" section. It is not necessary to also complete a Scars DBQ.

5C. COMMENTS, IF ANY:

SECTION VI - DIAGNOSTIC TESTING

NOTE - If diagnostic test results are in the medical record and reflect the Veteran's current seizure (epilepsy) disorder, repeat testing is not required.

6A. HAVE ANY IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED?

YES NO (If "Yes," check all that apply)

<input type="checkbox"/> Magnetic resonance imaging (MRI)	Date: _____	Results: _____
<input type="checkbox"/> Computed tomography (CT)	Date: _____	Results: _____
<input type="checkbox"/> Cerebrospinal fluid CSF examination	Date: _____	Results: _____
<input type="checkbox"/> Electroencephalography (EEG)	Date: _____	Results: _____
<input type="checkbox"/> Neuropsychologic testing	Date: _____	Results: _____
<input type="checkbox"/> Other (describe): _____	Date: _____	Results: _____

6B. 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 VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S EPILEPSY OR SEIZURE (epilepsy) DISORDER IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe the impact of the Veteran's seizure (epilepsy) disorder, providing one or more examples):

SECTION VIII - REMARKS

8. 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: