Department of Veterans Affairs

TUBERCULOSIS 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 ACTIVE OR LATENT TUBERCULOSIS (TB)?

☐ YES ☐ NO

1B. IF NO, HAS THE VETERAN HAD A POSITIVE SKIN TEST FOR TB WITHOUT ACTIVE DISEASE?

☐ YES ☐ NO

1C. IF NO, HAS THE VETERAN HAD A POSITIVE QUANTIFERON-TB GOLD TEST WITHOUT ACTIVE DISEASE?

☐ YES ☐ NO

1D. IF YES TO EITHER QUESTION A, B OR C ABOVE, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO TB CONDITIONS:

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

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

SECTION II - MEDICAL HISTORY

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

2B. IS THE VETERAN UNDERGOING TREATMENT OR HAS HE OR SHE COMPLETED TREATMENT FOR A TB CONDITION, INCLUDING ACTIVE TB, POSITIVE SKIN TEST OR LABORATORY EVIDENCE OF TB (positive quantiferon-TB gold test) WITHOUT ACTIVE DISEASE?

☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING:

Date treatment began: _____

If completed, date of completion: _____

If not completed, anticipated date of completion: _____

2C. LIST MEDICATIONS CURRENTLY OR PREVIOUSLY USED FOR TREATMENT OF TB CONDITION:

SECTION III - PULMONARY TB

3A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH PULMONARY TUBERCULOSIS?

☐ YES ☐ NO

IF YES, IS THE CONDITION:

☐ ACTIVE

☐ INACTIVE

If inactive, date condition became inactive: _____

3B. DOES THE VETERAN HAVE ANY RESIDUAL FINDINGS, SIGNS AND/OR SYMPTOMS DUE TO PULMONARY TB?

☐ YES ☐ NO

IF YES, INDICATE RESIDUALS:

☐ Emphysema
☐ Dyspnea on exertion
☐ Requires oxygen therapy
☐ Episodes of acute respiratory failure
☐ Moderately advanced lesions
☐ Far advanced lesions (diagnosed at any time while the disease process was active)
☐ Pulmonary hypertension
☐ Right ventricular hypertrophy
☐ Cor pulmonale (right heart failure)
☐ Impairment of health

If checked, describe: _____

☐ Other, describe: _____

SECTION III - PULMONARY TUBERCULOSIS (Continued)

3C. HAS THE VETERAN HAD THORACOPLASTY DUE TO TB?

☐ YES ☐ NO Date of procedure: _____

IF YES, HAS THE VETERAN HAD RESECTION OF ANY RIBS INCIDENT TO THORACOPLASTY?

☐ YES ☐ NO

IF YES, INDICATE NUMBER OF RIBS INVOLVED: ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 or 6 ☐ More than 6

SECTION IV - NON-PULMONARY TB

4A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH NON-PULMONARY TUBERCULOSIS?

☐ YES ☐ NO

IF YES, CHECK ALL NON-PULMONARY TB CONDITIONS THAT APPLY:

- ☐ Tuberculous pleurisy
- ☐ Tuberculous peritonitis
- ☐ Tuberculosis meningitis
- ☐ Skeletal TB
- ☐ Genitourinary TB
- ☐ Gastrointestinal TB
- ☐ Tuberculous lymphadenitis
- ☐ Cutaneous TB
- ☐ Ocular TB
- ☐ Other, describe: _____

4B. FOR ALL CHECKED CONDITIONS, INDICATE WHETHER THE CONDITION IS ACTIVE OR INACTIVE; IF INACTIVE, PROVIDE DATE CONDITION BECAME INACTIVE:

4C. DOES THE VETERAN HAVE ANY RESIDUALS FROM ANY OF THE NON-PULMONARY TB CONDITIONS?

☐ YES ☐ NO IF YES, DESCRIBE: ALSO COMPLETE APPROPRIATE QUESTIONNAIRES FOR THE SPECIFIC RESIDUAL CONDITIONS.

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 OR SYMPTOMS?

☐ 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.

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 Comments Section below. It is not necessary to also complete a Scars DBQ.

5C. COMMENTS, IF ANY:

SECTION VI - DIAGNOSTIC TESTING

NOTE: If test results are in the medical record and reflect the Veteran's current respiratory condition, repeat testing is not required.

6A. HAVE IMAGING STUDIES OR PROCEDURES BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ Chest x-ray Date: _____ Results: _____

☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____

☐ Computerized axial tomography (CT) Date: _____ Results: _____

☐ High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (HRCT)
Date: _____ Results: _____

☐ Other, specify: _____ Date: _____ Results: _____

6B. HAS PULMONARY FUNCTION TESTING (PFT) BEEN PERFORMED?

☐ YES ☐ NO

IF YES, DO PFT RESULTS REPORTED BELOW REFLECT THE VETERAN'S CURRENT PULMONARY FUNCTION?

☐ YES ☐ NO

6C. PULMONARY FUNCTION TESTING IS NOT REQUIRED IN ALL INSTANCES. IF PFTs HAVE NOT BEEN COMPLETED, PROVIDE REASON:

☐ Veteran requires outpatient oxygen therapy

☐ Veteran has had 1 or more episodes of acute respiratory failure

☐ Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or pulmonary hypertension

☐ Veteran has had exercise capacity testing and results are 20 ml/kg/min or less

☐ Other, describe: _____

6D. PFT RESULTS

Date: _____

Pre-bronchodilator:		Post-bronchodilator, if indicated:	
FEV-1:	_____ % predicted	FEV-1:	_____ % predicted
FVC :	_____ % predicted	FVC :	_____ % predicted
FEV-1/FVC:	_____ %	FEV-1/FVC:	_____ %
DLCO:	_____ % predicted		

6E. WHICH TEST RESULT MOST ACCURATELY REFLECTS THE VETERAN'S CURRENT PULMONARY FUNCTION?

☐ FEV-1

☐ FEV-1/FVC

☐ FVC

☐ DLCO

6F. IF POST-BRONCHODILATOR TESTING HAS NOT BEEN COMPLETED, PROVIDE REASON:

☐ Pre-bronchodilator results are normal

☐ Post-bronchodilator testing not indicated for Veteran's condition

☐ Post-bronchodilator testing not indicated in Veteran's particular case

If checked, provide reason: _____

☐ Other, describe: _____

6G. IF DIFFUSION CAPACITY OF THE LUNG FOR CARBON MONOXIDE BY THE SINGLE BREATH METHOD (DLCO) TESTING HAS NOT BEEN COMPLETED, PROVIDE REASON:

☐ Not indicated for Veteran's condition

☐ Not indicated in Veteran's particular case

☐ Not valid for Veteran's particular case

☐ Other, describe: _____

6H. DOES THE VETERAN HAVE MULTIPLE RESPIRATORY CONDITIONS?

☐ YES ☐ NO

IF YES, LIST CONDITIONS AND INDICATE WHICH CONDITION IS PREDOMINANTLY RESPONSIBLE FOR THE LIMITATION IN PULMONARY FUNCTION, IF ANY LIMITATION IS PRESENT:

6I. HAS EXERCISE CAPACITY TESTING BEEN PERFORMED?

☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING:

☐ Maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation)

☐ Maximum oxygen consumption of 15-20 ml/kg/min (with cardiac or respiratory limit)

SECTION VI - DIAGNOSTIC TESTING (Continued)

6J. 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 TUBERCULOSIS CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S TUBERCULOSIS CONDITIONS, 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: