OMB Control No. 2900-0778
Respondent Burden: 15 minutes

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

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - Your patient 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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/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 THE 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 IN ITEM 1B

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 VA FORM 21-0960G-4, INTESTINAL SURGERY (BOWEL RESECTION, COLOSTOMY, ILEOSTOMY) DISABILITY BENEFITS QUESTIONNAIRE

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY NON-SURGICAL NON-INFECTIOUS INTESTINAL CONDITION(S)?

☐ 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

☐ 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 SECTION I, DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," complete Items 7B thru 7E)*

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 ITEM 7C?

☐ 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 FORMAT IN ITEMS 7C AND 7D

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

8A. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS

☐ YES ☐ NO

IF YES, ARE ANY OF THE SCARS PAINFUL AND/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN 39 SQUARE cm *(6 square inches)*?

☐ YES ☐ NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE.

8B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO

IF YES, DESCRIBE *(Brief summary)*

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 - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

12A. PHYSICIAN'S SIGNATURE	12B. PHYSICIAN'S PRINTED NAME	12C. DATE SIGNED

12D. PHYSICIAN'S PHONE AND FAX NUMBER	12E. PHYSICIAN'S MEDICAL LICENSE NUMBER	12F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain additional medical information, including additional examinations if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to: _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete a form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain . If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.