



## PERITONEAL ADHESIONS 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 A PERITONEAL ADHESION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO PERITONEAL ADHESIONS:

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 PERITONEAL ADHESIONS, LIST USING ABOVE FORMAT:

### SECTION II - MEDICAL HISTORY

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

2B. DOES THE VETERAN HAVE A HISTORY OF OPERATIVE, TRAUMATIC OR INFECTIOUS (INTRAABDOMINAL) PROCESS?

YES  NO

IF YES, INDICATE ORGAN(S) AFFECTED (check all that apply):

STOMACH  GALL BLADDER  LIVER  SMALL INTESTINES  LARGE INTESTINES  OTHER: \_\_\_\_\_

2C. HAS THE VETERAN HAD SEVERE PERITONITIS, RUPTURED APPENDIX, PERFORATED ULCER OR OPERATION WITH DRAINAGE?

YES  NO

2D. DOES THE VETERAN HAVE A CURRENT DIAGNOSIS OF PERITONEAL ADHESIONS?

YES  NO

IF YES, INDICATE ORGAN(S) AFFECTED (check all that apply):

STOMACH  GALL BLADDER  LIVER  SMALL INTESTINES  LARGE INTESTINES  OTHER: \_\_\_\_\_

2E. DOES THE VETERAN HAVE ANY SIGNS AND/OR SYMPTOMS DUE TO PERITONEAL ADHESIONS?

YES  NO IF YES, INDICATE SIGNS AND SYMPTOMS: (check all that apply)

DELAYED MOTILITY OF BARIUM MEAL (on X-ray)  NAUSEA  
 PARTIAL OR COMPLETE BOWEL OBSTRUCTION  VOMITING  
 REFLEX DISTURBANCES  ABDOMINAL DISTENTION  
 PAIN  CONSTIPATION (perhaps alternating with diarrhea)

2F. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

YES  NO LIST MEDICATIONS: \_\_\_\_\_

### SECTION III - SEVERITY OF MANIFESTATIONS OF PERITONEAL ADHESIONS

**NOTE** - Indicate level of severity of signs and/or symptoms, if present: (Check all that apply in each level)

3A. LEVEL IV

SEVERE  DEFINITE PARTIAL OBSTRUCTION SHOWN BY X-RAY  FREQUENT EPISODES OF SEVERE COLIC DISTENSION  FREQUENT EPISODES OF SEVERE NAUSEA  FREQUENT EPISODES OF SEVERE VOMITING  
 PROLONGED EPISODES OF SEVERE COLIC DISTENSION  PROLONGED EPISODES OF SEVERE NAUSEA  PROLONGED EPISODES OF SEVERE VOMITING

3B. LEVEL III

MODERATELY SEVERE  PARTIAL OBSTRUCTION MANIFESTED BY DELAYED MOTILITY OF BARIUM MEAL  LESS FREQUENT EPISODES OF PAIN  LESS PROLONGED EPISODES OF PAIN

3C. LEVEL II

MODERATE  PULLING PAIN ON ATTEMPTING WORK OR AGGRAVATED BY MOVEMENTS OF THE BODY  OCCASIONAL EPISODES OF COLIC PAIN  OCCASIONAL EPISODES OF NAUSEA  OCCASIONAL EPISODES OF CONSTIPATION (Perhaps alternating with diarrhea)  ABDOMINAL DISTENSION

3D. LEVEL I

MILD, DESCRIBE: \_\_\_\_\_

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

4A. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION 1, DIAGNOSIS?

YES  NO

IF YES, ARE ANY OF THE SCARS PAINFUL 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)

4B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION 1, DIAGNOSIS?

YES  NO (If "Yes," describe - brief summary):

**SECTION V - DIAGNOSTIC TESTING**

5. HAS THE VETERAN HAD LABORATORY OR OTHER DIAGNOSTIC STUDIES PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO (If "Yes," provide type of test or procedure, date and results - brief summary):

**SECTION VI - FUNCTIONAL IMPACT**

6. BASED ON YOUR EXAMINATION AND/OR THE VETERAN'S HISTORY, DOES THE VETERAN'S PERITONEAL ADHESION(S) IMPACT HIS OR HER ABILITY TO WORK?

YES  NO (If "Yes," describe the impact of each of the veteran's peritoneal adhesions, providing one or more examples)

**SECTION VII - REMARKS**

7. REMARKS (If any)

**SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

8A. PHYSICIAN'S SIGNATURE		8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED
8D. PHYSICIAN'S PHONE AND FAX NUMBER	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. PHYSICIAN'S ADDRESS	

**NOTE** - VA may request 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](http://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, 58/VA21/22/28, 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 the 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](http://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.