OMB Approved No. 2900-XXXX
Respondent Burden: 30 minutes

KIDNEY CONDITIONS (NEPHROLOGY) 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 use the information you provide on this questionnaire to process the Veteran's claim.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH A KIDNEY CONDITION?

☐ YES ☐ NO

(If "No," provide rationale/reason (e.g. veteran does not currently have any known kidney condition(s)) ______ *)*

(If "Yes," indicate diagnosis/es: (check all that apply)

☐ Diabetic nephropathy	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Glomerulonephritis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Hydronephrosis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Interstitial nephritis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Kidney transplant	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Nephrosclerosis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Nephrp;otjoasos	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Renal artery stenosis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Ureterolithiasis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Other kidney condition *(specify diagnosis, providing only diagnoses that pertain to kidney conditions)*	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Other kidney condition *(specify diagnosis, providing only diagnoses that pertain to kidney conditions)*	ICD CODE: ______	DATE OF DIAGNOSIS: ______

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO KIDNEY CONDITION(S), LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S CURRENT KIDNEY CONDITION(S) *(Give a brief summary)*

SECTION III - RENAL DYSFUNCTION

3A. DOES THE VETERAN HAVE RENAL DYSFUNCTION?

☐ YES ☐ NO

(If "Yes," does the veteran require regular dialysis?

☐ YES ☐ NO

(If "Yes," skip to Item 3B)

(If "No," indicate severity of renal findings, signs and/or symptoms: (check all that apply)

☐ No symptoms

☐ Proteinuria *(albuminuria)*

(If checked, indicate frequency: (check all that apply)

☐ Recurring ☐ Constant ☐ Persistent

☐ Edema *(due to renal dysfunction)*

(If checked, indicate frequency: (check all that apply)

☐ Some ☐ Transient ☐ Slight ☐ Persistent

☐ Anorexia *(due to renal dysfunction)*

☐ Weight loss *(due to renal dysfunction)*

(If checked, provide percent of loss of individual's baseline weight: ______ *%)*

Note: "Baseline weight" means the average weight for the two-year period preceding onset of the disease.

☐ Generalized poor health *(due to renal dysfunction)*

☐ Lethargy *(due to renal dysfunction)*

☐ Weakness *(due to renal dysfunction)*

☐ Limitation of exertion *(due to renal dysfunction)*

☐ Able to perform only sedentary activity, due to persistent edema caused by renal dysfunction

☐ Markedly decreased function of other organ systems, especially the cardiovascular system, caused by renal dysfunction *(If checked, describe)*:

3B. DOES THE VETERAN HAVE HYPERTENSION AND/OR HEART DISEASE DUE TO RENAL DYSFUNCTION OR CAUSED BY ANY KIDNEY CONDITION?

☐ YES ☐ NO *(If "Yes," also complete the VA Form 21-0960A-3, Hypertension Disability Benefits Questionnaire and VA Form 21-0960A-4, Non-Ischemic Heat Disease Disability Benefits Questionnaire)*

SECTION IV - NEPHROLITHIASIS, HYDRONEPHROSIS, URETEROLITHIASIS OR URETERAL STRICTURE

4A. DOES THE VETERAN HAVE NEPHROLITHIASIS, HYDRONEPHROSIS, URETEROLITHIASIS OR STRICTURE OF THE URETER?

☐ YES ☐ NO

(If "Yes,"does the veteran have any of the following: (check all that apply)

- ☐ No symptoms or attacks of colic
- ☐ Occasional attacks of colic
- ☐ Frequent attacks of colic
- ☐ Requires catheter drainage
- ☐ Causing infection *(pyonephrosis)*
- ☐ Causing hydronephrosis
- ☐ Causing impaired kidney function

4B. DOES THE VETERAN HAVE RECURRENT STONE FORMATION?

☐ YES ☐ NO

(If "Yes," indicate treatment: (check all that apply))

- ☐ No treatment *(no diet or drug therapy)*
- ☐ Requiring diet therapy
- ☐ Requiring drug therapy
- ☐ Requiring invasive or non-invavsive procedures
  (If checked, indicate average number of times per year recurrent stone formation requires invavsive or non-invavsive procedures):
  ☐ 0 to 1/year ☐ 2/year ☐ more than 2/year

SECTION V - INFECTIONS OF THE KIDNEY AND/OR URINARY TRACT

5. DOES THE VETERAN HAVE KIDNEY ABSCESS, BLADDER FISTULA, URINARY TRACT OR ANY OTHER KIDNEY OR URINARY TRACT INFECTIONS?

☐ YES ☐ NO

(If "Yes,"check all of the following treatment modalities that apply)

- ☐ No treatment
- ☐ Drainage
- ☐ Hospitalization
- ☐ *(If checked, indicate frequency of hospitalization):*
  - ☐ 1 or 2 per year
  - ☐ More than 2 per year
- ☐ Intensive management
  - ☐ Continuous
  - ☐ Intermittent
  - ☐ Long-term drug therapy
    (If intensive management is checked, indicate treatment dates for courses of treatment): ____________________

SECTION VI - KIDNEY TRANSPLANT OR REMOVAL

6A. HAS A KIDNEY BEEN REMOVED?

☐ YES ☐ NO

(If "Yes," provide reason)

- ☐ Kidney donation
- ☐ Due to disease
- ☐ Due to trauma or injury

6B. HAS A THE VETERAN HAD A KIDNEY TRANSPLANT?

☐ YES ☐ NO

(If "Yes," date of admission): *(Date of discharge):*

SECTION VII - NEOPLASM

7. HAS THE VETERAN HAD A NEOPLASM OF THE URINARY SYSTEM?

☐ YES ☐ NO

(If "Yes," also complete the VA Form 21-0960O-1, Tumors and Neoplasms Disability Benefits Questionnaire)

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

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

☐ YES ☐ NO

(If "Yes," describe):

SECTION IX - DIAGNOSTIC TESTING

NOTE: If laboratory test results are in the medical record and reflect the veteran's current renal function, repeat testing is not required.

9A. HAS THE VETERAN HAD LABORATORY OR OTHER DIAGNOSTIC STUDIES PERFORMED?

☐ YES ☐ NO

(If "Yes,"provide most recent results, if available):

9B. LABORATORY STUDIES

	Test	Date	Result
☐	BUN	Date: ______	Result: ______
☐	Creatinine	Date: ______	Result: ______
☐	EGFR	Date: ______	Result: ______

9C. URINALYSIS

	Test	Date	Result
☐	Hyaline casts	Date: ______	Result: ______
☐	Granular casts	Date: ______	Result: ______
☐	RBC's/HPF	Date: ______	Result: ______
☐	Protein *(albumin)*	Date: ______	Result: ______
☐	Spot urine for protein/creatinine ratio	Date: ______	Result: ______
☐	24 hour protein *(albumin)*	Date: ______	Result: ______

9D. URINE MICROALBUMIN

Urine *(microalbumin)* Date: ______ Result: ______

9E. 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 AND REMARKS

10. DOES THE VETERAN'S KIDNEY CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of each of the veteran's kidney condition, providing one or more examples:*

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 NUMBER	12E. PHYSICIAN'S MEDICAL LICENSE NUMBER	12F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain additional medical information, including an examination, 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 required to obtain or retain benefits. 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 30 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.