



HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA 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 ON REVERSE 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 HEMATOLOGIC AND/OR LYMPHATIC CONDITION?

YES NO

(If "No," provide rationale (e.g. veteran does not currently have any known hematologic or lymphatic condition(s): _____)

(If "Yes," check the veteran's condition and provide ICD code and date of diagnosis:

- Acute lymphocytic leukemia (ALL) ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Acute myelogenous leukemia (AML) ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Chronic myelogenous leukemia (CML) ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Hodgkin's disease ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Non-Hodgkin's lymphoma ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Anemia ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Thrombocytopenia ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Polycythemia vera ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Sickle cell anemia ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Splenectomy ICD CODE: _____ DATE OF DIAGNOSIS: _____
- Hairy cell leukemia: if checked, complete the Hairy Cell and other B-Cell Leukemias Disability Questionnaire, VA Form 21-0960B-1
- Other hematologic or lymphatic condition(s): if checked complete Item 1B

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO HEMATOLOGIC OR LYMPHATIC CONDITION(S)

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 HEMATOLOGIC OR LYMPHATIC CONDITION(S), LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

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

2B. INDICATE THE STATUS OF THE CONDITION

ACTIVE REMISSION NOT APPLICABLE

SECTION III - TREATMENT

3A. HAS THE VETERAN COMPLETED ANY TYPE OF TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR ANY LYMPHATIC OR HEMATOLOGIC CONDITION, INCLUDING LEUKEMIA?

YES NO (If "Yes," indicate treatment type(s)) (Check all that apply)

- Watchful waiting
- Bone marrow transplant, if checked provide: Date of hospital admission and location _____
Date of hospital discharge after transplant _____
- Surgery, if checked describe: _____
- Radiation therapy, if checked provide: Date of most recent treatment _____
Date of completion of treatment or anticipated date of completion _____
- Antineoplastic chemotherapy, if checked provide: Date of most recent treatment _____
Date of completion of treatment or anticipated date of completion _____
- Other therapeutic procedure and/or treatment (describe): _____
Date of procedure: _____
Date of completion of treatment or anticipated date of completion: _____

3B. DOES THE VETERAN HAVE AN ANEMIA AND/OR THROMBOCYTOPENIA CONDITION, INCLUDING ANEMIA AND/OR THROMBOCYTOPENIA CAUSED BY TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC CONDITION?

YES NO

(If "Yes," is continuous medication required for control?) YES NO (If "Yes," list medication(s): _____)

SECTION IV - CONDITIONS, COMPLICATIONS AND/OR RESIDUALS

4A. DOES THE VETERAN CURRENTLY HAVE ANY CONDITIONS, COMPLICATIONS AND/OR RESIDUALS DUE TO A HEMATOLOGIC OR LYMPHATIC DISORDER OR DUE TO TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC DISORDER?

YES NO

(If "Yes," do they cause any of the following findings, signs or symptoms?)

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

- Weakness
- Easy fatigability
- Light-headedness
- Shortness of breath
- Headaches
- Dyspnea on mild exertion
- Dyspnea at rest
- Tachycardia
- Syncope
- Cardiomegaly
- High output congestive heart failure
- Complications or residuals of treatment requiring transfusion of platelets or red blood cells

(If checked, indicate frequency:

- At least once per year but less than once every 3 months
- At least once every 3 months
- At least once every 6 weeks

4B. DOES THE VETERAN CURRENTLY HAVE ANY OTHER CONDITIONS, COMPLICATIONS AND/OR RESIDUALS OF TREATMENT FROM A HEMATOLOGIC OR LYMPHATIC DISORDER?

YES NO *(If "Yes," describe (brief summary))*

SECTION V - RECURRING INFECTIONS

5. DOES THE VETERAN CURRENTLY HAVE ANY CONDITIONS, COMPLICATIONS AND/OR RESIDUALS OF TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC DISORDER THAT RESULT IN RECURRING INFECTIONS?

YES NO

(If "Yes," indicate frequency of infections:

- Less than once per year
- At least once per year but less than once every 3 months
- At least once every 3 months
- At least once every 6 weeks

SECTION VI - THROMBOCYTOPENIA (Primary, Idiopathic or Immune)

6. DOES THE VETERAN HAVE THROMBOCYTOPENIA?

YES NO

(If "Yes," check all that apply)

- Stable platelet count of 100,000 or more
- Stable platelet count between 70,000 and 100,000
- Platelet count between 20,000 and 70,000
- Platelet count of less than 20,000
- With active bleeding
- Requiring treatment with medication
- Requiring treatment with transfusions

SECTION VII - POLYCYTHEMIA VERA

7. DOES THE VETERAN HAVE POLYCYTHEMIA VERA?

YES NO

(If "Yes," check all that apply)

- Stable with or without continuous medication
- Requiring phlebotomy
- Requiring myelosuppressant treatment

NOTE: If there are complications due to polycythemia vera such as hypertension, gout, stroke or thrombotic disease, also complete appropriate questionnaire(s).

SECTION VIII - SICKLE CELL ANEMIA

8. DOES THE VETERAN HAVE SICKLE CELL ANEMIA?

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

- Asymptomatic
- In remission
- With identifiable organ impairment
- Following repeated hemolytic sickling crises with continuing impairment of health
- Painful crises several times a year
- Repeated painful crises, occurring in skin, joints, bones or any major organs
- With anemia, thrombosis and infarction
- Symptoms preclude other than light manual labor
- Symptoms preclude even light manual labor

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

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

 YES NO *(If "Yes," describe (brief summary))***SECTION X - DIAGNOSTIC TESTING****NOTE:** If testing has been performed and reflects veteran's current condition, no further testing is required. Provide most recent CBC, hemoglobin level or platelet count appropriate to the veteran's condition:

10A. HEMOGLOBIN LEVEL (gm/100ml): _____ Date _____

10B. PLATELET COUNT: _____ Date _____

10C. 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 XI - FUNCTIONAL IMPACT AND REMARKS**

11. DOES THE VETERAN'S HEMATOLOGIC AND/OR LYMPHATIC CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

 YES NO *(If "Yes," describe impact of each of the veteran's hematologic and/or lymphatic conditions, providing one or more examples:*12. 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.

13A. PHYSICIAN'S SIGNATURE		13B. PHYSICIAN'S PRINTED NAME	13C. DATE SIGNED
13D. PHYSICIAN'S PHONE NUMBER	13E. PHYSICIAN'S MEDICAL LICENSE NUMBER	13F. 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 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.