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

Department of Veterans Affairs

TUBERCULOSIS 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 ACTIVE/LATENT TUBERCULOSIS (TB)?

☐ YES ☐ NO *(If "No," complete Items 1B, 1C and 1D) (If "Yes," complete Item 1E)*

1B. PROVIDE RATIONALE/REASON *(e.g., veteran does not currently have any known TB condition(s))*

1C. HAS THE VETERAN HAD A POSITIVE SKIN TEST FOR TB WITHOUT ACTIVE DISEASE?

☐ YES ☐ NO

1D. HAS THE VETERAN HAD A POSITIVE QUANTIFERON-TB GOLD TEST WITHOUT ACTIVE DISEASE?

☐ YES ☐ NO

1E. 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 -

1F. IF ADDITIONAL DIAGNOSIS 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. INDICATE TB CONDITION *(check all that apply)*

☐ PULMONARY TB
☐ NON-PULMONARY TB

2C. 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): _____

(List medications used for treatment of TB condition): _____

SECTION III - PULMONARY TUBERCULOSIS

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

☐ YES ☐ NO

(If "Yes," is the condition):

☐ ACTIVE ☐ INACTIVE

(If inactive, date condition became inactive) _____

SECTION III - PULMONARY TUBERCULOSIS *(Continued)*

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

☐ YES ☐ NO

(If "Yes," indicate residuals) (Check all that apply)

- ☐ 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
- ☐ Other, describe: _____

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

☐ YES ☐ NO

(If "Yes," 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 TUBERCULOSIS

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING NON-PULMONARY TB CONDITIONS?

☐ YES ☐ NO

(If "Yes," check all 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 CONDITIONS CHECKED IN ITEM 4A, INDICATE WHETHER THE CONDITION IS ACTIVE OR INACTIVE, AND IF INACTIVE, THE DATE CONDITION BECAME INACTIVE

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

☐ YES ☐ NO *(If "Yes," describe and also complete the appropriate questionnaire(s) for the specific condition)*

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

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

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

SECTION VI - DIAGNOSTIC TESTING

NOTE: If pulmonary function testing (PFT) is indicated, and results are in the medical record and reflect the veteran's current respiratory function, repeat testing is not required.

6A. HAVE PFTs BEEN PERFORMED?

☐ YES ☐ NO

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

FEV 1: _____ % predicted Date of test: _____

FEV 1 post bronchodilator, if indicated/performed: _____ % predicted Date of test: _____

FEV 1/FVC: _____ % predicted Date of test: _____

FEV 1/FVC post bronchodilator, if indicated/performed: _____ % predicted Date of test: _____

FVC : _____ % predicted Date of test: _____

DLCO *(Diffusion capacity of the lung for carbon monoxide):* _____ % predicted Date of test: _____

(If post-bronchodilator testing was not conducted, provide an explanation of why not)

☐ Post-bronchodilator testing is not indicated for the veterans condition

☐ Other reason: _____

NOTE: POST-BRONCHODILATOR TESTING IS ONLY INDICATED FOR PULMONARY CONDITIONS WHICH MAY BE RESPONSIVE TO BRONCHODILATORS.

NOTE: FOR OBSTRUCTIVE LUNG CONDITIONS, FEV1 MOST ACCURATELY REFLECTS THE SEVERITY OF THE CONDITION. FOR RESTRICTIVE LUNG CONDITIONS, FVC MOST ACCURATELY REFLECTS THE SEVERITY OF THE CONDITION.

6B. DOES THE VETERAN HAVE MULTIPLE PULMONARY DIAGNOSES?

☐ YES ☐ NO

(If "Yes," list multiple pulmonary diagnoses): _____

(If there are multiple pulmonary diagnoses, is it possible to differentiate the PFT results that represent conditions other than pulmonary TB from those that reflect the veteran's pulmonary condition due to pulmonary TB?)

☐ YES ☐ NO

(If "Yes," differentiate contribution of each condition diagnosed to overall PFT results): _____

(If "No," explain why it is not possible to differentiate PFT results by specific condition):

6C. HAVE A CHEST X-RAY, CT SCAN AND/OR OTHER DIAGNOSTIC IMAGING STUDIES BEEN PERFORMED?

☐ YES ☐ NO

(If "Yes," provide results): Date(s) of test(s):

6D. 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(S) IMPACT HIS OR HER ABILITY TO WORK?

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

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 NUMBER	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. 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, 58/VA21/22/28, 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 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. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.