



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)

- | | | |
|--|-----------------|--------------------------|
| <input type="checkbox"/> Diabetic nephropathy | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Glomerulonephritis | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Hydronephrosis | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Interstitial nephritis | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Kidney transplant | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Nephrosclerosis | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Nephropathy | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Renal artery stenosis | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Ureterolithiasis | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> Other kidney condition
(specify diagnosis, providing only diagnoses that pertain to kidney conditions) | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> 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 Heart 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-invasive procedures

(If checked, indicate average number of times per year recurrent stone formation requires invasive or non-invasive 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 21-09600-1, 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

<input type="checkbox"/> BUN	Date: _____	Result: _____
<input type="checkbox"/> Creatinine	Date: _____	Result: _____
<input type="checkbox"/> EGFR	Date: _____	Result: _____

9C. URINALYSIS

<input type="checkbox"/> Hyaline casts	Date: _____	Result: _____
<input type="checkbox"/> Granular casts	Date: _____	Result: _____
<input type="checkbox"/> RBC's/HPF	Date: _____	Result: _____
<input type="checkbox"/> Protein (<i>albumin</i>)	Date: _____	Result: _____
<input type="checkbox"/> Spot urine for protein/creatinine ratio	Date: _____	Result: _____
<input type="checkbox"/> 24 hour protein (<i>albumin</i>)	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.