OMB Control No. 2900-xxxx
Respondent Burden: 15 minutes

Department of Veterans Affairs

DIABETES MELLITUS 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 - You 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. SELECT THE VETERAN'S CONDITION:

- ☐ DIABETES MELLITUS TYPE I
- ☐ DIABETES MELLITUS TYPE II
- ☐ IMPAIRED FASTING GLUCOSE
- ☐ DOES NOT MEET CRITERIA FOR DIAGNOSIS OF DIABETES
- ☐ OTHER *(Specify, providing only diagnoses that pertain to DM or its complications)* ____________

(If checked, provide only diagnoses below that pertain to diabetes mellitus conditions)

1B. DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
1C. DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
1D. DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1E. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO DIABETES MELLITUS LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

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

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ NONE, MANAGED BY RESTRICTED DIET ONLY
- ☐ PRESCRIBED ORAL HYPOGLYCEMIC AGENT(S)
- ☐ PRESCRIBED INSULIN 1 INJECTION PER DAY
- ☐ PRESCRIBED INSULIN MORE THAN 1 INJECTION PER DAY
- ☐ OTHER

2B. DOES THE VETERAN REQUIRE REGULATION OF ACTIVITIES AS PART OF MEDICAL MANAGEMENT OF DIABETES MELLITUS?

☐ YES ☐ NO *(If "Yes," provide one or more examples of how the veteran must regulate his or her activities):*

NOTE - For VA purposes regulation of activities can be defined as avoidance of strenuous occupational and recreational activities with the intention if avoiding hypoglycemic episodes.

2C. HOW FREQUENTLY DOES THE VETERAN VISIT HIS OR HER DIABETIC CARE PROVIDER?

☐ LESS THAN 2 TIMES PER MONTH ☐ 2 TIMES PER MONTH ☐ WEEKLY

2D. HOW MANY EPISODES OF KETOACIDOSIS REQUIRING HOSPITALIZATION OVER THE PAST 12 MONTHS?

☐ 0 ☐ 1 ☐ 2 ☐ 3 OR MORE

2E. HOW MANY EPISODES OF HYPOGLYCEMIA REQUIRING HOSPITALIZATION OVER THE PAST 12 MONTHS?

☐ 0 ☐ 1 ☐ 2 ☐ 3 OR MORE

2F. HAS THE VETERAN HAD PROGRESSIVE UNINTENTIONAL WEIGHT LOSS ATTRIBUTABLE TO DIABETES MELLITUS?

☐ YES ☐ NO *(If "Yes," provide percent of loss of individual's baseline weight):* ________ %

NOTE - For VA purposes, "baseline weight" means the average weight for the two-year period preceding the onset of the disease.

2G. HAS THE VETERAN HAD PROGRESSIVE LOSS OF STRENGTH ATTRIBUTABLE TO DIABETES MELLITUS?

☐ YES ☐ NO

SECTION III - COMPLICATIONS OF DIABETES MELLITUS

3A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING RECOGNIZED COMPLICATIONS OF DIABETES MELLITUS?

☐ YES ☐ NO

(If "Yes," indicate the conditions below) (Check all that apply)

- ☐ DIABETIC PERIPHERAL NEUROPATHY
- ☐ DIABETIC PERIPHERAL NEUROPATHY OR RENAL DYSFUNCTION CAUSED BY DIABETES MELLITUS
- ☐ DIABETIC RETINOPATHY

NOTE - For all checked boxes, also complete appropriate Questionnaire(s). VA Form 21-0960N-2, Eye Disability Benefits Questionnaire must be completed by an ophthalmologist or optometrist)

SECTION III - COMPLICATIONS OF DIABETES MELLITUS *(Continued)*

3B. DOES THE VETERAN HAVE ANY OF THE FOLLOWING CONDITIONS THAT ARE AT LEAST AS LIKELY AS NOT *(at least 50% probability)* CAUSED OR PERMANENTLY AGGRAVATED *(but not due to the natural progress of the disease)* BY DIABETES MELLITUS?

☐ YES ☐ NO

(If "Yes," indicate the conditions below) (Check all that apply)

☐ ERECTILE DYSFUNCTION *(If checked also complete the VA form 21-0960J-2, Male Reproductive Organs Disability Benefits Questionnaire)*

☐ CARDIOVASCULAR CONDITIONS *(If checked also complete the VA forms 21-0960A-1 through 21-0960A-4, Cardiac Disability Benefits Questionnaires)*

☐ HYPERTENSION CAUSED BY RENAL DISEASE *(If checked also complete VA form 21-0960A-3, Hypertension Disability Benefits Questionnaire)*

☐ PERIPHERAL VASCULAR DISEASE *(If checked also complete VA form 21-0960A-2, Arteries and Veins Disability Benefits Questionnaire)*

☐ STROKE *(If checked also complete VA form 21-0960A-2, Arteries and Veins Disability Benefits Questionnaire)*

☐ SKIN CONDITIONS *(If checked also complete VA form 21-0960F-2, Skin Conditions Disability Benefits Questionnaire)*

☐ EYE CONDITIONS OTHER THAN DIABETIC RETINOPATHY *(If checked also complete VA form 21-0960N-2, Eye Conditions Disability Benefits Questionnaire which must be completed by an ophthalmologist or optometrist)*

☐ OTHER CONDITIONS *(Describe) (If checked also complete appropriate Disability Benefits Questionnaire(s)* ____________________

____

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

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

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

SECTION V - DIAGNOSTIC TESTING

5A. TEST RESULTS USED TO MAKE THE DIAGNOSIS OF DIABETES MELLITUS *(If known) (Check all that apply)*

NOTE: If laboratory test results are in the medical record, repeat testing is not required. A glucose tolerance test is not required for VA purposes; report this test only if already completed.

☐ FASTING PLASMA GLUCOSE TEST (FPG) OF $\geq$126 MG/DL ON 2 OR MORE OCCASIONS *(Dates:* ____________________*)*

☐ A1C OF 6.5% OR GREATER ON 2 OR MORE OCCASIONS *(Dates:* ____________________*)*

☐ 2-HR PLASMA GLUCOSE OF $\geq$ 200 MG/DL ON GLUCOSE TOLERANCE TEST *(Dates:* ____________________*)*

☐ RANDOM PLASMA GLUCOSE OF $\geq$ 200 MG/DL WITH CLASSIC SYMPTOMS OF HYPERGLYCEMIA *(Dates:* ____________________*)*

☐ OTHER *(Describe):* ____________________

5B. CURRENT TEST RESULTS

MOST RECENT A1C, IF AVAILABLE: ____________________ *(Date:* ____________________*)*

SECTION VI - FUNCTIONAL IMPACT AND REMARKS

6. DOES THE VETERAN'S DIABETES MELLITUS CONDITION *(and complications of DM if present)* IMPACT HIS OR HER ABILITY TO WORK? *(Impact on ability to work may also be addressed on the individual Questionnaire(s) for other diabetes-associated conditions and/or complications, if completed)*

☐ YES ☐ NO *(If Yes," describe impact of each of the Veteran's DM, (and or diabetes-associated conditions and/or complications, if present) providing one or more examples)*

7. REMARKS *(If any)*

SECTION VII - 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 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. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.