



## 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 consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim.

### SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH ACTIVE OR LATENT TUBERCULOSIS (TB)?

YES  NO

1B. IF NO, HAS THE VETERAN HAD A POSITIVE SKIN TEST FOR TB WITHOUT ACTIVE DISEASE?

YES  NO

1C. IF NO, HAS THE VETERAN HAD A POSITIVE QUANTIFERON-TB GOLD TEST WITHOUT ACTIVE DISEASE?

YES  NO

1D. IF YES TO EITHER QUESTION A, B OR C ABOVE, 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 -

1E. IF THERE ARE ADDITIONAL DIAGNOSES 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. 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: \_\_\_\_\_

2C. LIST MEDICATIONS CURRENTLY OR PREVIOUSLY USED FOR TREATMENT OF TB CONDITION:

### SECTION III - PULMONARY TB

3A. DOES THE VETERAN NOW HAVE OR HAS HE OR 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 TB?

YES  NO

IF YES, INDICATE RESIDUALS:

- 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
- If checked, describe: \_\_\_\_\_
- Other, describe: \_\_\_\_\_

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

YES  NO 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 TB**

4A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH NON-PULMONARY TUBERCULOSIS?

YES  NO

IF YES, CHECK ALL NON-PULMONARY TB CONDITIONS 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 CHECKED CONDITIONS, INDICATE WHETHER THE CONDITION IS ACTIVE OR INACTIVE; IF INACTIVE, PROVIDE DATE CONDITION BECAME INACTIVE:

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

YES  NO IF YES, DESCRIBE: ALSO COMPLETE APPROPRIATE QUESTIONNAIRES FOR THE SPECIFIC RESIDUAL CONDITIONS.

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

5A. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION 1?

YES  NO

IF YES, ARE ANY OF THE SCARS PAINFUL AND/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN 39 SQUARE CM (6 square inches)?

YES  NO IF YES, ALSO COMPLETE A SCARS QUESTIONNAIRE.

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

YES  NO

IF YES, DESCRIBE (*brief summary*):

**SECTION VI - DIAGNOSTIC TESTING**

**NOTE:** If test results are in the medical record and reflect the Veteran's current respiratory condition, repeat testing is not required.

6A. HAVE IMAGING STUDIES OR PROCEDURES BEEN PERFORMED?

YES  NO

IF YES, CHECK ALL THAT APPLY:

- Chest x-ray Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Magnetic resonance imaging (MRI) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Computerized axial tomography (CT) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (HRCT) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Other, specify: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

6B. HAS PULMONARY FUNCTION TESTING (PFT) BEEN PERFORMED?

YES  NO

IF YES, DO PFT RESULTS REPORTED BELOW REFLECT THE VETERAN'S CURRENT PULMONARY FUNCTION?

YES  NO

6C. PULMONARY FUNCTION TESTING IS NOT REQUIRED IN ALL INSTANCES. IF PFTs HAVE NOT BEEN COMPLETED, PROVIDE REASON:

- Veteran requires outpatient oxygen therapy
- Veteran has had 1 or more episodes of acute respiratory failure
- Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or pulmonary hypertension
- Veteran has had exercise capacity testing and results are 20 ml/kg/min or less
- Other, describe: \_\_\_\_\_

6D. PFT RESULTS

Date: \_\_\_\_\_

Pre-bronchodilator:

FEV-1: \_\_\_\_\_ % predicted  
FVC : \_\_\_\_\_ % predicted  
FEV-1/FVC: \_\_\_\_\_ % predicted  
DLCO: \_\_\_\_\_ % predicted

Post-bronchodilator, if indicated:

FEV-1: \_\_\_\_\_ % predicted  
FVC : \_\_\_\_\_ % predicted  
FEV-1/FVC: \_\_\_\_\_ % predicted  
DLCO: \_\_\_\_\_ % predicted

6E. WHICH TEST RESULT MOST ACCURATELY REFLECTS THE VETERAN'S CURRENT PULMONARY FUNCTION?

- FEV-1
- FEV-1/FVC
- FVC
- DLCO

6F. IF POST-BRONCHODILATOR TESTING HAS NOT BEEN COMPLETED, PROVIDE REASON:

- Pre-bronchodilator results are normal
- Post-bronchodilator testing not indicated for veteran's condition
- Post-bronchodilator testing not indicated in veteran's particular case
- If checked, provide reason: \_\_\_\_\_
- Other, describe: \_\_\_\_\_

6G. IF DIFFUSION CAPACITY OF THE LUNG FOR CARBON MONOXIDE BY THE SINGLE BREATH METHOD (DLCO) TESTING HAS NOT BEEN COMPLETED, PROVIDE REASON:

- Not indicated for Veteran's condition
- Not indicated in Veteran's particular case
- Not valid for Veteran's particular case
- Other, describe: \_\_\_\_\_

6H. DOES THE VETERAN HAVE MULTIPLE RESPIRATORY CONDITIONS?

YES  NO

IF YES, LIST CONDITIONS AND INDICATE WHICH CONDITION IS PREDOMINANTLY RESPONSIBLE FOR THE LIMITATION IN PULMONARY FUNCTION, IF ANY LIMITATION IS PRESENT:

6I. HAS EXERCISE CAPACITY TESTING BEEN PERFORMED?

YES  NO

IF YES, COMPLETE THE FOLLOWING:

- Maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation)
- Maximum oxygen consumption of 15-20 ml/kg/min (with cardiorespiratory limit)

**SECTION VI - DIAGNOSTIC TESTING (Continued)**

6J. 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 IMPACT HIS OR HER ABILITY TO WORK?

YES  NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S TUBERCULOSIS CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

**SECTION XI - REMARKS**

8. REMARKS (*If any*)

**SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

**CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

9A. PHYSICIAN'S SIGNATURE

9B. PHYSICIAN'S PRINTED NAME

9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBER

9E. PHYSICIAN'S MEDICAL LICENSE NUMBER

9F. 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](http://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](http://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.