OMB Control No. 2900-0778
Respondent Burden: 15 minutes

Department of Veterans Affairs

SLEEP APNEA 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 HAVE OR HAS HE/SHE EVER HAD SLEEP APNEA?

☐ YES ☐ NO *(If "Yes," complete Item 1B)*

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SLEEP APNEA AND CHECK DIAGNOSTIC TYPE:

☐ OBSTRUCTIVE ICD Code: _____ Date of diagnosis: _____

☐ CENTRAL ICD Code: _____ Date of diagnosis: _____

☐ MIXED, COMPONENTS OF BOTH ICD Code: _____ Date of diagnosis: _____

☐ OTHER SLEEP DISORDER *(specify):* ICD Code: _____ Date of diagnosis: _____

_____

1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO A DIAGNOSIS OF SLEEP APNEA, LIST USING ABOVE FORMAT:

NOTE - The diagnosis of sleep apnea must be confirmed by a sleep study, provide the sleep study results in Section 5, Diagnostic Testing. If other respiratory condition is diagnosed, complete VA Form 21-0960L-1, Respiratory Conditions Disability Benefits Questionnaire and/or VA Form 21-0960C-6, Narcolepsy Disability Benefits Questionnaire in lieu of this one.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S SLEEP DISORDER CONDITION *(brief summary)*:

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF A SLEEP DISORDER CONDITION?

☐ YES ☐ NO *(If "Yes," list only those medications required for the veteran's sleep disorder condition):*

2C. DOES THE VETERAN REQUIRE THE USE OF A BREATHING ASSISTANCE DEVICE SUCH AS A CONTINUOUS POSITIVE AIRWAY PRESSURE *(CPAP)* MACHINE?

☐ YES ☐ NO

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO SLEEP APNEA?

☐ YES ☐ NO

(If, "Yes," check all that apply)

- ☐ Persistent daytime hypersomnolence
- ☐ Evidence of chronic respiratory failure with carbon dioxide retention
- ☐ Cor pulmonale
- ☐ Requires tracheostomy
- ☐ Other, describe: _____

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

4A. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I?

☐ 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 cm (6 square inches?)

☐ YES ☐ NO

(If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

4B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

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

SECTION V - DIAGNOSTIC TESTING

NOTE - If diagnostic test results are in the medical record and reflect the veteran's current sleep apnea condition, repeat testing is not required.

5A. HAS A SLEEP STUDY BEEN PERFORMED?

☐ YES ☐ NO

(If, "Yes," does the veteran have documented sleep disorder breathing?)

☐ YES ☐ NO

Date of sleep study: _____

Name of facility where sleep study performed, if known: _____

Results: _____

5B. 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 VI - FUNCTIONAL IMPACT

6. DOES THE VETERAN'S SLEEP APNEA IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of the veteran's sleep apnea, providing one or more examples):*

SECTION VII - REMARKS

7. 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.

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE AND FAX NUMBER	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain additional medical information, including additional examinations 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 low 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.