



**OSTEOMYELITIS 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
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**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 OSTEOMYELITIS?

YES     NO    (If "No," complete Item 1B)

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO OSTEOMYELITIS

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO OSTEOMYELITIS, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S OSTEOMYELITIS (brief summary):

2B. INDICATE LOCATION OF INITIAL INFECTION (Check all that apply):

- PELVIS
- CERVICAL VERTEBRAE
- THORACOLUMBAR VERTEBRAE
- LONG BONES OF UPPER EXTREMITY    Side affected:  Right     Left
- LONG BONES OF LOWER EXTREMITY    Side affected:  Right     Left
- FINGER(S):     Right digit(s) affected \_\_\_\_\_     Left digit(s) affected \_\_\_\_\_
- TOE(S):     Right digit(s) affected \_\_\_\_\_     Left digit(s) affected \_\_\_\_\_
- OTHER, Specify: \_\_\_\_\_

EXTENSION INTO JOINTS

If checked, indicate joints affected:

- Right:  Shoulder     Elbow     Wrist     Hip     Knee     Ankle  
 Multiple hand joints     Multiple foot joints
- Left:  Shoulder     Elbow     Wrist     Hip     Knee     Ankle  
 Multiple hand joints     Multiple foot joints

OTHER, Specify: \_\_\_\_\_

2C. HAS THE VETERAN HAD MEDICAL TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING MEDICAL TREATMENT FOR OSTEOMYELITIS?

YES     NO

(If "Yes," describe treatment): \_\_\_\_\_

Date treatment started: \_\_\_\_\_

Date treatment completed or anticipated date of completion: \_\_\_\_\_

**SECTION II - MEDICAL HISTORY (continued)**

2D. HAS THE VETERAN HAD SURGICAL TREATMENT FOR OSTEOMYELITIS?

YES  NO

(If "Yes," indicate surgical procedure and date (if multiple procedures, indicate below)):

Procedure #1: \_\_\_\_\_

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

Procedure #2: \_\_\_\_\_

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

If additional surgical procedures, list using above format: \_\_\_\_\_

2E. PROVIDE STATUS OF THE VETERAN'S CURRENT OSTEOMYELITIS CONDITION:

ACUTE  SUBACUTE  CHRONIC  INACTIVE  RESOLVED  OTHER describe: \_\_\_\_\_

**SECTION III - RECURRENT INFECTIONS**

3A. HAS THE VETERAN HAD ANY ADDITIONAL EPISODES OR RECURRING INFECTIONS OF OSTEOMYELITIS FOLLOWING THE INITIAL INFECTION?

YES  NO (If "Yes," complete Section III.) (If "No," skip to Section IV.)

(If "Yes," indicate number of additional episodes):

1  2  3  4  5 or more

3B. LOCATION OF RECURRENT INFECTIONS (check all that apply):

- PELVIS
- CERVICAL VERTEBRAE
- THORACOLUMBAR VERTEBRAE
- LONG BONES OF UPPER EXTREMITY Side affected:  Right  Left
- LONG BONES OF LOWER EXTREMITY Side affected:  Right  Left
- FINGER(S):  Right digit(s) affected \_\_\_\_\_  Left digit(s) affected \_\_\_\_\_
- TOE(S):  Right digit(s) affected \_\_\_\_\_  Left digit(s) affected \_\_\_\_\_
- OTHER, Specify: \_\_\_\_\_

EXTENSION INTO JOINTS

(If checked, indicate joints affected):

- Right:  Shoulder  Elbow  Wrist  Hip  Knee  Ankle  
 Multiple hand joints  Multiple foot joints
- Left:  Shoulder  Elbow  Wrist  Hip  Knee  Ankle  
 Multiple hand joints  Multiple foot joints

OTHER, Specify: \_\_\_\_\_

3C. DATES OF RECURRENT INFECTION

Indicate dates of recurrences:

Date of recurrence #1: \_\_\_\_\_ Site of recurrent infection: \_\_\_\_\_

Date of recurrence #2: \_\_\_\_\_ Site of recurrent infection: \_\_\_\_\_

Date of recurrence #3: \_\_\_\_\_ Site of recurrent infection: \_\_\_\_\_

If there are additional recurrences, list using above format: \_\_\_\_\_

**SECTION IV - SIGNS, SYMPTOMS AND FINDINGS**

4A. DOES THE VETERAN CURRENTLY HAVE ANY SIGNS OR FINDINGS ATTRIBUTABLE TO OSTEOMYELITIS OR TREATMENT FOR OSTEOMYELITIS?

YES  NO (If "Yes," check all that apply):

- Involucrum
- Sequestrum
- Discharging sinus
- Amyloidosis secondary to chronic infection
- Anemia

(If checked, provide CBC results in diagnostic testing section).

Decreased joint function or range of motion due to osteomyelitis or residuals of treatment  
If checked, indicate affected joints and ALSO complete appropriate Questionnaire for each affected joint and/or spinal segment.

Right:  Shoulder  Elbow  Wrist  Hip  Knee  Ankle  Single foot joint

Multiple hand joints  Multiple foot joints  Single hand joint

Left:  Shoulder  Elbow  Wrist  Hip  Knee  Ankle  Single foot joint

Multiple hand joints  Multiple foot joints  Single hand joint

Cervical vertebral joint(s)  Thoracolumbar vertebral joint(s) Specific vertebral joint(s) affected \_\_\_\_\_

**SECTION IV - SIGNS, SYMPTOMS AND FINDINGS** (continued)

4B. DOES THE VETERAN CURRENTLY HAVE ANY SYMPTOMS ATTRIBUTABLE TO OSTEOMYELITIS OR TREATMENT FOR OSTEOMYELITIS?

YES  NO

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

- Pain (If checked, describe severity, duration and location): \_\_\_\_\_
- Swelling (If checked, describe severity, duration and location): \_\_\_\_\_
- Tenderness (If checked, describe severity, duration and location): \_\_\_\_\_
- Erythema (If checked, describe severity, duration and location): \_\_\_\_\_
- Warmth (If checked, describe severity, duration and location): \_\_\_\_\_
- Malaise (If checked, describe symptoms and duration): \_\_\_\_\_
- Other Symptoms, describe: \_\_\_\_\_

**SECTION V - AMPUTATION**

5. HAS THE VETERAN HAD AN AMPUTATION DUE TO OSTEOMYELITIS?

YES  NO

(If "Yes," also complete VA Form 21-0960M-1 Amputations Disability Benefits Questionnaire.)

**SECTION VI - ASSISTIVE DEVICES**

6A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

YES  NO

(If "Yes," identify assistive devices used (check all that apply and indicate frequency):

- |                                       |                   |                                     |                                  |                                   |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair   | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace(s)     | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutch(es)   | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s)      | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker       | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

(If the veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition):

**SECTION VII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES**

7. DUE TO THE VETERAN'S OSTEOMYELITIS OR RESIDUALS OF TREATMENTS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTION REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLY SERVE THE VETERAN.  
 NO

(If "Yes," indicate extremities for which this applies):

Right upper  Left upper  Right lower  Left lower

For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary)

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

8A. DOES THE VETERAN HAVE ANY SCARS (*SURGICAL OR OTHERWISE*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I ABOVE?

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 VA Form 21-0960F-1 Scars/Disfigurement Disability Benefits Questionnaire)*

8B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I ABOVE?

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

**SECTION IX - DIAGNOSTIC TESTING**

9A. HAVE IMAGING OR LABORATORY STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO

*(If "Yes," indicate tests performed, dates and results):*

- Bone scan Date of test: \_\_\_\_\_ Results: \_\_\_\_\_
- X-ray Date of test: \_\_\_\_\_ Results: \_\_\_\_\_
- MRI Date of test: \_\_\_\_\_ Results: \_\_\_\_\_
- Complete blood count (CBC) Date of test: \_\_\_\_\_ Results: \_\_\_\_\_
- C-reactive protein (CRP) Date of test: \_\_\_\_\_ Results: \_\_\_\_\_
- Erythrocyte sedimentation rate (ESR) Date of test: \_\_\_\_\_ Results: \_\_\_\_\_
- Blood culture Date of test: \_\_\_\_\_ Results: \_\_\_\_\_
- Bone biopsy and culture Date of test: \_\_\_\_\_ Results: \_\_\_\_\_
- Other, describe: \_\_\_\_\_ Date of test: \_\_\_\_\_ Results: \_\_\_\_\_

9B. 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 OSTEOMYELITIS IMPACT HIS OR HER ABILITY TO WORK?

YES  NO

*(If "Yes," describe the impact of the Veteran's osteomyelitis or residuals of treatment, 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 AND FAX NUMBER	12E. PHYSICIAN'S MEDICAL LICENSE NUMBER	12F. PHYSICIAN'S ADDRESS

NOTE - VA may request 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](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 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](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.