OMB Approved No. 2900-0778
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

# 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 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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

## SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR 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 questions 3B and 3C) (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):*

| | | | | | |
|---|---|---|---|---|---|
| ☐ Wheelchair | Frequency of use: | ☐ Occasional | ☐ Regular | ☐ Constant |
| ☐ Brace(s) | Frequency of use: | ☐ Occasional | ☐ Regular | ☐ Constant |
| ☐ Crutch(es) | Frequency of use: | ☐ Occasional | ☐ Regular | ☐ Constant |
| ☐ Cane(s) | Frequency of use: | ☐ Occasional | ☐ Regular | ☐ Constant |
| ☐ Walker | Frequency of use: | ☐ Occasional | ☐ Regular | ☐ Constant |
| ☐ Other: _____ | Frequency of use: | ☐ Occasional | ☐ Regular | ☐ Constant |

_____

_____

*(If the veteran uses any assistive devices, specify the condition and identify the assitive 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, DIAGNOSIS?

☐ YES ☐ NO

*(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than or equal to 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, DIAGNOSIS?

☐ 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

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):*

## SECTION XI - REMARKS

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.benefits.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 voluntary. 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.