OMB Control No. 2900-0778
Respondent Burden: 30 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

HEPATITIS, CIRRHOSIS AND OTHER LIVER CONDITIONS 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 A LIVER CONDITION?

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

1B. SELECT THE VETERAN'S CONDITION *(check all that apply):*

☐ Hepatitis A	ICD code: _____	Date of diagnosis: _____	*(complete Section III)*
☐ Hepatitis B	ICD code: _____	Date of diagnosis: _____	*(complete Section III)*
☐ Hepatitis C	ICD code: _____	Date of diagnosis: _____	*(complete Section III)*
☐ Autoimmune hepatitis	ICD code: _____	Date of diagnosis: _____	*(complete Section III)*
☐ Drug-induced hepatitis	ICD code: _____	Date of diagnosis: _____	*(complete Section III)*
☐ Hemochromatosis	ICD code: _____	Date of diagnosis: _____	*(complete Section III)*
☐ Cirrhosis of the liver	ICD code: _____	Date of diagnosis: _____	*(complete Section IV)*
☐ Primary biliary cirrhosis	ICD code: _____	Date of diagnosis: _____	*(complete Section IV)*
☐ Sclerosing cholangitis	ICD code: _____	Date of diagnosis: _____	*(complete Section IV)*
☐ Liver transplant candidate	ICD code: _____	Date of diagnosis: _____	*(complete Section V)*
☐ Liver transplant	ICD code: _____	Date of diagnosis: _____	*(complete Section V)*

☐ Other liver conditions:

Other diagnosis #1: _____ ICD code: _____ Date of diagnosis: _____

Other diagnosis #2: _____ ICD code: _____ Date of diagnosis: _____

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

NOTE: Determination of these conditions requires documentation by appropriate serologic testing, abnormal liver function tests, and/or abnormal liver biopsy or imaging tests. If test results are documented in the medical record, additional testing is not required.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including cause, onset and course)* OF THE VETERAN'S LIVER CONDITIONS *(brief summary):*

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S LIVER CONDITIONS?

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR THE LIVER CONDITIONS:

SECTION III - HEPATITIS

(Including hepatitis A, B and C, autoimmune or drug-induced hepatitis, any other infectious liver disease and chronic liver disease without cirrhosis)

3A. DOES THE VETERAN CURRENTLY HAVE SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC OR INFECTIOUS LIVER DISEASES?

☐ YES ☐ NO

IF YES, INDICATE SIGNS AND SYMPTOMS ATTRIBUTABLE TO CHRONIC OR INFECTIOUS LIVER DISEASES *(check all that apply):*

☐ Fatigue
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Malaise
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Anorexia
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Nausea
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Vomiting
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Arthralgia
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Weight loss
If checked, provide baseline weight _____ and current weight _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
Also, indicate if this weight loss has been sustained for three months or longer: ☐ YES ☐ NO

☐ Right upper quadrant pain
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Hepatomegaly

☐ Condition requires dietary restriction
If checked, describe dietary restrictions: _____

☐ Condition results in other indications of malnutrition
If checked, describe other indications of malnutrition: _____

☐ Other, describe: _____

3B. HAS THE VETERAN BEEN DIAGNOSED WITH HEPATITIS C?

☐ YES ☐ NO

IF YES, INDICATE RISK FACTORS *(check all that apply):*

☐ Unknown
☐ No known risk factors
☐ Organ transplant before 1992
☐ Transfusions of blood or blood products before 1992
☐ Hemodialysis
☐ Accidental exposure to blood by health care workers *(to include combat medic or corpsman)*
☐ Intravenous drug use or intranasal cocaine use
☐ High risk sexual activity

☐ Other direct percutaneous exposure to blood *(such as by tattooing, body piercing, acupuncture with non-sterile needles, shared toothbrushes and/or shaving razors)*
If checked, describe: _____

☐ Other, describe: _____

3C. HAS THE VETERAN HAD ANY INCAPACITATING EPISODES *(with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)* DUE TO THE LIVER CONDITIONS DURING THE PAST 12 MONTHS?

☐ YES ☐ NO

IF YES, PROVIDE THE TOTAL DURATION OF THE INCAPACITATING EPISODES OVER THE PAST 12 MONTHS:

☐ Less than 1 week
☐ At least 1 week but less than 2 weeks
☐ At least 2 weeks but less than 4 weeks
☐ At least 4 weeks but less than 6 weeks
☐ 6 weeks or more

NOTE: For VA purposes, an "incapacitating episode" means a period of acute symptoms severe enough to require bed rest and treatment by a physician.

SECTION IV - CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS AND CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS

4A. DOES THE VETERAN CURRENTLY HAVE SIGNS OR SYMPTOMS ATTRIBUTABLE TO CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS OR CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS?

☐ YES ☐ NO

IF YES, INDICATE SIGNS AND SYMPTOMS ATTRIBUTABLE TO CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS OR CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS *(check all that apply):*

☐ Weakness

If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Anorexia

If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Abdominal pain

If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Malaise

If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Weight loss

If checked, provide baseline weight: _____ and current weight: _____

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

Also, indicate if this weight loss has been sustained for three months or longer: ☐ YES ☐ NO

☐ Ascites

If checked, indicate frequency and severity *(check all that apply):*

☐ 1 episode ☐ 2 or more episodes ☐ Periods of remission between attacks ☐ Refractory to treatment

Date of last episode of ascites: _____

☐ Hepatic encephalopathy

If checked, indicate frequency and severity *(check all that apply):*

☐ 1 episode ☐ 2 or more episodes ☐ Periods of remission between attacks ☐ Refractory to treatment

Date of last episode of hepatic encephalopathy: _____

☐ Hemorrhage from varices or portal gastropathy *(erosive gastritis)*

If checked, indicate frequency and severity *(check all that apply):*

☐ 1 episode ☐ 2 or more episodes ☐ Periods of remission between attacks ☐ Refractory to treatment

Date of last episode of hemorrhage from varices or portal gastropathy: _____

☐ Portal hypertension

☐ Splenomegaly

☐ Persistent jaundice

SECTION V - LIVER TRANSPLANT AND/OR LIVER INJURY

5A. IS THE VETERAN A LIVER TRANSPLANT CANDIDATE?

☐ YES ☐ NO

5B. IS THE VETERAN CURRENTLY HOSPITALIZED AWAITING TRANSPLANT?

☐ YES ☐ NO

Date of hospital admission for this condition: _____

5C. HAS THE VETERAN UNDERGONE A LIVER TRANSPLANT?

☐ YES ☐ NO

Date(s) of surgery: _____ _____ _____

Date of hospital discharge: _____

Current signs and symptoms: _____

5D. HAS THE VETERAN HAD AN INJURY TO THE LIVER?

☐ YES ☐ NO

IF YES, DOES THE VETERAN HAVE PERITONEAL ADHESIONS RESULTING FROM AN INJURY TO THE LIVER?

☐ YES ☐ NO

(If "Yes," ALSO complete the VA Form 21-0960G-6, Peritoneal Adhesions Disability Benefits Questionnaire)

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

6A. 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)

SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS *(Continued)*

6B. 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 VII - DIAGNOSTIC TESTING

NOTE: Diagnosis of hepatitis C must be confirmed by recombinant immunoblot assay (RIBA). If this information is of record, repeat RIBA test is not required. If testing has been performed and reflects veteran's current condition, no further testing is required for this examination report.

7A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ EUS *(Endoscopic ultrasound)* Date: _____ Results: _____

☐ ERCP *(Endoscopic retrograde cholangiopancreatography)* Date: _____ Results: _____

☐ Transhepatic cholangiogram Date: _____ Results: _____

☐ MRI or MRCP *(magnetic resonance cholangiopancreatography)* Date: _____ Results: _____

☐ CT Date: _____ Results: _____

☐ Other, describe: _____ Date: _____ Results: _____

7B. HAVE LABORATORY STUDIES BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ Recombinant immunoblot assay *(RIBA)* Date: _____ Results: _____

☐ Hepatitis C genotype Date: _____ Results: _____

☐ Hepatitis C viral titers Date: _____ Results: _____

☐ AST Date: _____ Results: _____

☐ ALT Date: _____ Results: _____

☐ Alkaline phosphatase Date: _____ Results: _____

☐ Bilirubin Date: _____ Results: _____

☐ INR (PT) Date: _____ Results: _____

☐ Creatinine Date: _____ Results: _____

☐ MELD score Date: _____ Results: _____

☐ Other, describe: _____ Date: _____ Results: _____

7C. HAS A LIVER BIOPSY BEEN PERFORMED?

☐ YES ☐ NO Date of test: _____ Results: _____

7D. 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 VIII - FUNCTIONAL IMPACT

8. DOES THE VETERAN'S LIVER CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S LIVER CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION IX - REMARKS

9. REMARKS *(If any)*

SECTION X - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

10A. PHYSICIAN'S SIGNATURE	10B. PHYSICIAN'S PRINTED NAME	10C. DATE SIGNED

10D. PHYSICIAN'S PHONE AND FAX NUMBER	10E. PHYSICIAN'S MEDICAL LICENSE NUMBER	10F. 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, 58VA21/22/28, 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 30 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.