

**Department of Veterans Affairs** **KIDNEY CONDITIONS (NEPHROLOGY) 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
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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. 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 KIDNEY CONDITION?

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

1B. INDICATE DIAGNOSIS (check all that apply):

<input type="checkbox"/> Diabetic nephropathy	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Glomerulonephritis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Hydronephrosis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Interstitial nephritis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Kidney transplant	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Nephrosclerosis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Nephrolithiasis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Renal artery stenosis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Ureterolithiasis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Neoplasm of the kidney	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Cholesterol emboli	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Cystic kidney disease	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Congenital kidney disorder	ICD CODE: _____	DATE OF DIAGNOSIS: _____
<input type="checkbox"/> Other inherited kidney disorder	ICD CODE: _____	DATE OF DIAGNOSIS: _____
Specify: _____		
<input type="checkbox"/> Other kidney condition (Specify diagnosis, providing only diagnoses that pertain to kidney 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 KIDNEY CONDITION(S), LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including cause, onset and course) OF THE VETERAN'S CURRENT KIDNEY CONDITION(S) (Give a brief summary):

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

YES  NO List medications taken for the diagnosed condition: \_\_\_\_\_

**SECTION III - RENAL DYSFUNCTION**

3A. DOES THE VETERAN HAVE RENAL DYSFUNCTION? (Evidence of renal dysfunction includes either persistent proteinuria, hematuria or GFR < 60 cc/min/1.73m2)

YES  NO (If yes complete questions 3B - 3D)

3B. DOES THE VETERAN REQUIRE REGULAR DIALYSIS?

YES  NO

**SECTION III - RENAL DYSFUNCTION (Continued)**

3C. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS DUE TO RENAL DYSFUNCTION?

YES  NO

(If yes check all that apply):

Proteinuria (albuminuria)

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

Recurring  Constant  Persistent

Edema (due to renal dysfunction)

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

Some  Transient  Slight  Persistent

Anorexia (due to renal dysfunction)

Weight loss (due to renal dysfunction)

If checked, provide baseline weight (average weight for 2-year period preceding onset of disease): \_\_\_\_\_ Provide current weight: \_\_\_\_\_

Generalized poor health (due to renal dysfunction)

Lethargy (due to renal dysfunction)

Weakness (due to renal dysfunction)

Limitation of exertion (due to renal dysfunction)

Able to perform only sedentary activity, due to persistent edema caused by renal dysfunction

Markedly decreased function of other organ systems, especially the cardiovascular system, caused by renal dysfunction (If checked, describe):

Other (If checked, describe):

3D. DOES THE VETERAN HAVE HYPERTENSION AND/OR HEART DISEASE DUE TO RENAL DYSFUNCTION OR CAUSED BY ANY KIDNEY CONDITION?

YES  NO

(If Yes, also complete VA Form 21-0960A-3, Hypertension Disability Benefits Questionnaire and/or VA Form 21-0960A-4, Heart Conditions (Including Ischemic and Non-Ischemic Heart Disease, Arrhythmias, Valvular Disease and Cardiac Surgery) Disability Benefits Questionnaire, as appropriate.)

**SECTION IV - UROLITHIASIS**

4A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD KIDNEY, URETAL OR BLADDER CALCULI (UROLITHIASIS)?

YES  NO

(If yes, complete questions 4B - 4D)

4B. INDICATE CURRENT/PAST LOCATION OF CALCULI

KIDNEY  URETER  BLADDER

4C. HAS THE VETERAN HAD TREATMENT FOR RECURRENT STONE FORMATION IN THE KIDNEY, URETER OR BLADDER?

YES  NO

(If yes, indicate treatment (Check all that apply)):

Diet therapy

If checked, specify diet and dates of use: \_\_\_\_\_

Drug therapy

If checked, list medication and dates of use: \_\_\_\_\_

Invasive or non-invasive procedures

If checked, indicate average number of times per year invasive or non-invasive procedures were required:

0 to 1/year  2/year  more than 2/year

Date and facility of most recent invasive or non-invasive procedure: \_\_\_\_\_

4D. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS DUE TO UROLITHIASIS?

YES  NO

(If yes, indicate severity (Check all that apply)):

No symptoms or attacks of colic

Causing infection (pyonephrosis)

Occasional attacks of colic

Causing hydronephrosis

Frequent attacks of colic

Causing impaired kidney function

Causing voiding dysfunction

Other, describe: \_\_\_\_\_

Requires catheter drainage

**SECTION V - INFECTIONS OF THE KIDNEY AND/OR URINARY TRACT**

5A. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT OR KIDNEY INFECTIONS?

YES  NO

*(If yes, complete questions 5B - 5C)*

5B. ETIOLOGY OF RECURRENT URINARY TRACT OR KIDNEY INFECTIONS:

5C. INDICATE ALL TREATMENT MODALITIES USED FOR RECURRENT URINARY TRACT OR KIDNEY INFECTIONS *(check all that apply)*:

No treatment

Long-term drug therapy

If checked, list medications used and indicate dates for courses of treatment over the past 12 months:

Hospitalization

If checked, indicate frequency of hospitalization:

1 or 2 per year  More than 2 per year

Drainage

If checked, indicate dates when drainage was performed over the past 12 months: \_\_\_\_\_

Continuous intensive management

If checked, indicate types of treatment and medications used over the past 12 months: \_\_\_\_\_

Intermittent intensive management

If checked, indicate types of treatment and medications used over the past 12 months: \_\_\_\_\_

Other, describe: \_\_\_\_\_

**SECTION VI - KIDNEY TRANSPLANT OR REMOVAL**

6A. HAS THE VETERAN HAD A KIDNEY TRANSPLANT OR REMOVAL?

YES  NO

*(If yes, complete questions 6B - 6C)*

6B. HAS THE VETERAN HAD A KIDNEY REMOVED?

YES  NO

*(If yes, provide reason):*

Kidney donation

Due to disease

Due to trauma or injury

Other, describe: \_\_\_\_\_

6C. HAS THE VETERAN HAD A KIDNEY TRANSPLANT?

YES  NO

If yes, date of transplant: \_\_\_\_\_

Name of treatment facility, date of admission and date of discharge for transplant:  
\_\_\_\_\_

**SECTION VII - TUMORS AND NEOPLASMS**

7A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS?

YES  NO

*(If yes, complete questions 7B - 7E)*

7B. IS THE NEOPLASM

BENIGN  MALIGNANT

7C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

YES  NO; WATCHFUL WAITING

**SECTION VII - TUMORS AND NEOPLASMS (Continued)**

7C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES? (Continued)

If "Yes," indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

- Treatment completed; currently in watchful waiting status
- Surgery  
If checked, describe: \_\_\_\_\_  
Date(s) of surgery: \_\_\_\_\_
- Radiation therapy  
Date of most recent treatment: \_\_\_\_\_ Date of completion of treatment or anticipated date of completion: \_\_\_\_\_
- Antineoplastic chemotherapy  
Date of most recent treatment: \_\_\_\_\_ Date of completion of treatment or anticipated date of completion: \_\_\_\_\_
- Other therapeutic procedure  
If checked, describe procedure: \_\_\_\_\_  
Date of most recent procedure: \_\_\_\_\_
- Other therapeutic treatment  
If checked, describe treatment: \_\_\_\_\_  
Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

7D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (INCLUDING METASTASES) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

- YES  NO (If yes, list residual conditions and complications (brief summary)):

7E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS, DESCRIBE USING THE ABOVE FORMAT:

**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 CONDITION 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 OR SYMPTOMS?

- YES  NO (If yes, describe (brief summary)):

**SECTION IX - DIAGNOSTIC TESTING**

NOTE: If laboratory test results are in the medical record and reflect the veteran's current renal function, repeat testing is not required. Provide testing completed appropriate to veteran's condition; testing indicated below is not indicated for every kidney condition.

9A. HAS THE VETERAN HAD LABORATORY OR OTHER DIAGNOSTIC STUDIES PERFORMED?

- YES  NO

(If yes, provide most recent results (if available)):

9B. LABORATORY STUDIES

- BUN      Date: \_\_\_\_\_      Result: \_\_\_\_\_
- Creatinine      Date: \_\_\_\_\_      Result: \_\_\_\_\_
- EGFR      Date: \_\_\_\_\_      Result: \_\_\_\_\_

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

9C. URINALYSIS

<input type="checkbox"/> Hyaline casts	Date: _____	Result: _____
<input type="checkbox"/> Granular casts	Date: _____	Result: _____
<input type="checkbox"/> RBC's/HPF	Date: _____	Result: _____
<input type="checkbox"/> Proteinuria ( <i>albumin</i> )	Date: _____	Result: _____
<input type="checkbox"/> Spot urine for protein/creatinine ratio	Date: _____	Result: _____
<input type="checkbox"/> 24 hour protein ( <i>mg/day</i> )	Date: _____	Result: _____

9D. SPOT URINE MICROALBUMIN/CREATININE

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

9E. 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 KIDNEY CONDITION(S), INCLUDING NEOPLASMS, IF ANY, IMPACT HIS OR HER ABILITY TO WORK?

YES  NO (If yes, describe impact of each of the veteran's kidney conditions, providing one or more examples):

**SECTION XI - REMARKS**

11. REMARKS

**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](http://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](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.