OMB Approved No. 2900-0779
Respondent Burden: 15 Minutes
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Department of Veterans Affairs

HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA 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 HEMATOLOGIC OR LYMPHATIC CONDITION?

☐ YES ☐ NO

IF YES, SELECT THE VETERAN'S CONDITION(S) *(check all that apply):*

☐ Acute lymphocytic leukemia (ALL)	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Acute myelogenous leukemia (AML)	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Chronic myelogenous leukemia (CML)	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Chronic lymphocytic leukemia (CLL)	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Hodgkin's disease	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Non-Hodgkin's lymphoma	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Multiple myeloma	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Myelodysplastic syndrome	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Plasmacytoma	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Anemia *(such as anemia of chronic disease, aplastic anemia, hemolytic anemia, iron or vitamin-deficient anemias, thalassemias, myelophthisic anemia, etc.)*	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Thrombocytopenia	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Polycythemia vera	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Sickle cell anemia	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Splenectomy	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Hairy cell or other B-cell leukemia: if checked, complete VA Form 21-0960B-1, Hairy Cell and other B-Cell Leukemias Disability Benefits Questionnaire		
☐ Other, specify		
Other diagnosis #1: _____	ICD CODE: _____	DATE OF DIAGNOSIS: _____
Other diagnosis #2: _____	ICD CODE: _____	DATE OF DIAGNOSIS: _____
Other diagnosis #3: _____	ICD CODE: _____	DATE OF DIAGNOSIS: _____

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HEMATOLOGIC OR LYMPHATIC CONDITION(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HEMATOLOGIC OR LYMPHATIC CONDITION *(Brief summary):*

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF A HEMATOLOGIC OR LYMPHATIC CONDITION, INCLUDING ANEMIA OR THROMBOCYTOPENIA CAUSED BY TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC CONDITION?

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR CONTROL OF THE VETERAN'S HEMATOLOGIC OR LYMPHATIC CONDITION, INCLUDING ANEMIA OR THROMBOCYTOPENIA CAUSED BY TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC CONDITION. PROVIDE THE NAME OF THE MEDICATION AND THE CONDITION THE MEDICATION IS USED TO TREAT:

2C. INDICATE THE STATUS OF THE PRIMARY HEMATOLOGIC OR LYMPHATIC CONDITION:

☐ ACTIVE ☐ REMISSION ☐ NOT APPLICABLE

SECTION III - TREATMENT

3. HAS THE VETERAN COMPLETED ANY TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING ANY TREATMENT FOR ANY HEMATOLOGIC OR LYMPHATIC CONDITION, INCLUDING LEUKEMIA?

☐ YES ☐ NO; WATCHFUL WAITING

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

☐ Bone marrow transplant, if checked provide:

Date of hospital admission and location: _____

Date of hospital discharge after transplant: _____

☐ Surgery, if checked describe: _____

Date(s) of surgery: _____

☐ Radiation therapy, if checked provide:

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

☐ Antineoplastic chemotherapy, if checked provide:

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: _____

SECTION IV - ANEMIA AND THROMBOCYTOPENIA *(Primary, secondary, idiopathic and immune)*

4A. DOES THE VETERAN HAVE ANEMIA OR THROMBOCYTOPENIA, INCLUDING THAT CAUSED BY TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC CONDITION?

☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING:

4B. DOES THE VETERAN HAVE ANEMIA?

☐ YES ☐ NO

IF YES, IS THE ANEMIA CAUSED BY TREATMENT FOR ANOTHER HEMATOLOGIC OR LYMPHATIC CONDITION?

☐ YES ☐ NO

IF YES, PROVIDE THE NAME OF THE OTHER HEMATOLOGIC OR LYMPHATIC CONDITION CAUSING THE SECONDARY ANEMIA:

_____

4C. DOES THE VETERAN HAVE THROMBOCYTOPENIA?

☐ YES ☐ NO

IF YES, IS THE THROMBOCYTOPENIA CAUSED BY TREATMENT FOR ANOTHER HEMATOLOGIC OR LYMPHATIC CONDITION?

☐ YES ☐ NO

IF YES, PROVIDE THE NAME OF THE OTHER HEMATOLOGIC OR LYMPHATIC CONDITION CAUSING THE SECONDARY THROMBOCYTOPENIA:

_____

IF YES, CHECK ALL THAT APPLY:

☐ Stable platelet count of 100,000 or more

☐ Stable platelet count between 70,000 and 100,000

☐ Platelet count between 20,000 and 70,000

☐ Platelet count of less than 20,000

☐ With active bleeding

☐ Other, describe: _____

4D. DOES THE VETERAN HAVE ANY COMPLICATIONS OR RESIDUALS OF TREATMENT REQUIRING TRANSFUSION OF PLATELETS OR RED BLOOD CELLS?

☐ YES ☐ NO

IF YES, INDICATE FREQUENCY OF TRANSFUSIONS IN THE PAST 12 MONTHS:

☐ None

☐ At least once per year but less than once every 3 months

☐ At least once every 3 months

☐ At least once every 6 weeks

SECTION V - FINDINGS, SIGNS AND SYMPTOMS

5. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS AND SYMPTOMS DUE TO A HEMATOLOGIC OR LYMPHATIC DISORDER OR TO TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC DISORDER?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

- ☐ Weakness If checked, describe: _____
- ☐ Easy fatigability If checked, describe: _____
- ☐ Light-headedness If checked, describe: _____
- ☐ Shortness of breath If checked, describe: _____
- ☐ Headaches If checked, describe: _____
- ☐ Dyspnea on mild exertion If checked, describe: _____
- ☐ Dyspnea at rest If checked, describe: _____
- ☐ Tachycardia If checked, describe: _____
- ☐ Syncope If checked, describe: _____
- ☐ Cardiomegaly
- ☐ High output congestive heart failure
- ☐ Other, describe: _____

SECTION VI - RECURRING INFECTIONS

6. DOES THE VETERAN CURRENTLY HAVE RECURRING INFECTIONS ATTRIBUTABLE TO ANY CONDITIONS, COMPLICATIONS OR RESIDUALS OF TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC DISORDER?

☐ YES ☐ NO

IF YES, INDICATE FREQUENCY OF INFECTIONS OVER PAST 12 MONTHS:

- ☐ None
- ☐ At least once per year but less than once every 3 months
- ☐ At least once every 3 months
- ☐ At least once every 6 weeks

SECTION VII - POLYCYTHEMIA VERA

7. DOES THE VETERAN HAVE POLYCYTHEMIA VERA?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

- ☐ Stable with or without continuous medication
- ☐ Requiring phlebotomy
- ☐ Requiring myelosuppressant treatment
- ☐ Other, describe: _____

NOTE: If there are complications due to polycythemia vera such as hypertension, gout, stroke or thrombotic disease, ALSO complete appropriate Questionnaire for each condition.

SECTION VIII - SICKLE CELL ANEMIA

8. DOES THE VETERAN HAVE SICKLE CELL ANEMIA?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

- ☐ Asymptomatic
- ☐ In remission
- ☐ With identifiable organ impairment
- ☐ Following repeated hemolytic sickling crises with continuing impairment of health
- ☐ Painful crises several times a year
- ☐ Repeated painful crises, occurring in skin, joints, bones or any major organs
- ☐ With anemia, thrombosis and infarction
- ☐ Symptoms preclude other than light manual labor
- ☐ Symptoms preclude even light manual labor
- ☐ Other, describe: _____

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

9A. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION 1, 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 IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS *(Continued)*

9B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO

IF YES, DESCRIBE *(Brief summary):*

SECTION X - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects veteran's current condition, no further testing is required. When appropriate, provide most recent complete blood count.

10A. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

IF YES, PROVIDE RESULTS:

Hemoglobin (gm/100ml):	_____	Date:	_____
Hematocrit:	_____	Date:	_____
Red blood cell (RBC) count:	_____	Date:	_____
White blood cell (WBC) count:	_____	Date:	_____
White blood cell differential count:	_____	Date:	_____
Platelet count:	_____	Date:	_____

10B. 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 XI - FUNCTIONAL IMPACT

11. DOES THE VETERAN'S HEMATOLOGIC AND/OR LYMPHATIC CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S HEMATOLOGIC AND/OR LYMPHATIC CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION XII - REMARKS

12. REMARKS *(If any)*

SECTION XIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

13A. PHYSICIAN'S SIGNATURE	13B. PHYSICIAN'S PRINTED NAME	13C. DATE SIGNED

13D. PHYSICIAN'S PHONE AND FAX NUMBER	13E. PHYSICIAN'S MEDICAL LICENSE NUMBER	13F. 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 30 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.