OMB Approved No. 2900-0781
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS, CHRONIC FATIGUE SYNDROME, OR TUBERCULOSIS) 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 BEFORE COMPLETING THIS 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.

NOTE - If the veteran has HIV-related illness, complete VA Form 21-0960I-2, if chronic fatigue syndrome complete VA Form 21-0960Q-1, or if tuberculosis complete VA Form 21-0960I-6 in lieu of this questionnaire.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN INFECTIOUS DISEASE? *(This is the condition the veteran is claiming or for which an exam has been requested)*

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

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

☐ MALARIA	ICD code: _____	Date of diagnosis: _____
☐ ASIATIC CHOLERA	ICD code: _____	Date of diagnosis: _____
☐ VISCERAL LEISHMANIASIS	ICD code: _____	Date of diagnosis: _____
☐ LEPROSY *(Hansen's disease)*	ICD code: _____	Date of diagnosis: _____
☐ LYMPHATIC FILARIASIS	ICD code: _____	Date of diagnosis: _____
☐ BARTONELLOSIS	ICD code: _____	Date of diagnosis: _____
☐ PLAGUE	ICD code: _____	Date of diagnosis: _____
☐ RELAPSING FEVER	ICD code: _____	Date of diagnosis: _____
☐ RHEUMATIC FEVER	ICD code: _____	Date of diagnosis: _____
☐ ENDOCARDITIS	ICD code: _____	Date of diagnosis: _____
☐ SYPHILIS	ICD code: _____	Date of diagnosis: _____
☐ BRUCELLOSIS	ICD code: _____	Date of diagnosis: _____
☐ TYPHUS SCRUB	ICD code: _____	Date of diagnosis: _____
☐ MELIOIDOSIS	ICD code: _____	Date of diagnosis: _____
☐ LYME DISEASE	ICD code: _____	Date of diagnosis: _____
☐ PARASITIC DISEASE, NOS	ICD code: _____	Date of diagnosis: _____
☐ OTHER *(specify):*		
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 INFECTIOUS DISEASES, LIST USING ABOVE FORMAT:

NOTE - The diagnosis of malaria depends on the identification of the malarial parasites in blood smears. If the veteran served in an endemic area and presents signs and symptoms compatible with malaria, the diagnosis may be based on clinical grounds alone. Relapses must be confirmed by the presence of malarial parasites in blood smears.

SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

☐ C-FILE (VA ONLY)

☐ OTHER, DESCRIBE: _____

SECTION III - MEDICAL HISTORY

3. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S INFECTIOUS DISEASE CONDITION(S) *(brief summary):*

SECTION IV -STATUS, SYMPTOMS AND RESIDUALS

4A. COMPLETE THE FOLLOWING SECTION(S) FOR EACH OF THE VETERAN'S INFECTIOUS DISEASE CONDITION(S):

Disease #1: _____

A. Status of disease: ☐ Active ☐ Inactive

If "Inactive," date condition became inactive: _____

B. Does the veteran have symptoms attributable to disease #1?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the veteran have residuals attributable to disease #1?

☐ Yes ☐ No

If "Yes," describe: _____

NOTE: If the veteran has symptoms or residuals, ALSO complete the appropriate questionnaire for each symptomatic or residual condition *(such as Skin, Heart, Peripheral or Central Nervous System, Respiratory and appropriate Joint and Gastrointestinal Questionnaire)*

Disease #2: _____

A. Status of disease: ☐ Active ☐ Inactive

If "Inactive," date condition became inactive: _____

B. Does the veteran have symptoms attributable to disease #2?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the veteran have residuals attributable to disease #2?

☐ Yes ☐ No

If "Yes," describe: _____

NOTE: If the veteran has symptoms or residuals, ALSO complete the appropriate questionnaire for each symptomatic or residual condition *(such as Skin, Heart, Peripheral or Central Nervous System, Respiratory and appropriate Joint and Gastrointestinal Questionnaire)*

Disease #3: _____

A. Status of disease: ☐ Active ☐ Inactive

If "Inactive," date condition became inactive: _____

B. Does the veteran have symptoms attributable to disease #3?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the veteran have residuals attributable to disease #3?

☐ Yes ☐ No

If "Yes," describe: _____

NOTE: If the veteran has symptoms or residuals, ALSO complete the appropriate questionnaire for each symptomatic or residual condition *(such as Skin, Heart, Peripheral or Central Nervous System, Respiratory and appropriate Joint and Gastrointestinal Questionnaire)*

4B. IF THE VETERAN HAS ANY ADDITIONAL INFECTIOUS DISEASE CONDITIONS, LIST AND DESCRIBE BY USING THE FORMAT SHOWN IN ITEM 4A.

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

5A. 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)*

5B. 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 VI - DIAGNOSTIC TESTING

NOTE - If testing has been performed and reflects veteran's current condition, repeat testing is not required.

6. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO *(If "Yes," provide type of test or procedure, date and results (brief summary):*

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S INFECTIOUS DISEASE CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the veteran's infectious disease condition(s), providing one or more examples):*

SECTION VIII - REMARKS

8. REMARKS *(If any):*

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBERS	9E. PHYSICIAN'S MEDICAL LICENSE NUMBER	9F. 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.