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

Department of Veterans Affairs

PERITONEAL ADHESIONS 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 PERITONEAL ADHESION?

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date is determined through record review or reported history.

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO PERITONEAL ADHESIONS:

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 PERITONEAL ADHESIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

2B. DOES THE VETERAN HAVE A HISTORY OF OPERATIVE, TRAUMATIC OR INFECTIOUS (INTRAABDOMINAL) PROCESS?

☐ YES ☐ NO IF YES, INDICATE ORGAN(S) AFFECTED *(check all that apply)*:

☐ STOMACH ☐ GALL BLADDER ☐ LIVER ☐ SMALL INTESTINES ☐ LARGE INTESTINES ☐ OTHER: _____

2C. HAS THE VETERAN HAD SEVERE PERITONITIS, RUPTURED APPENDIX, PERFORATED ULCER OR OPERATION WITH DRAINAGE?

☐ YES ☐ NO

2D. DOES THE VETERAN HAVE A CURRENT DIAGNOSIS OF PERITONEAL ADHESIONS?

☐ YES ☐ NO IF YES, INDICATE ORGAN(S) AFFECTED *(check all that apply)*:

☐ STOMACH ☐ GALL BLADDER ☐ LIVER ☐ SMALL INTESTINES ☐ LARGE INTESTINES ☐ OTHER: _____

2E. DOES THE VETERAN HAVE ANY SIGNS AND/OR SYMPTOMS DUE TO PERITONEAL ADHESIONS?

☐ YES ☐ NO IF YES, INDICATE SIGNS AND SYMPTOMS: *(check all that apply)*

☐ DELAYED MOTILITY OF BARIUM MEAL *(on X-ray)*
☐ PARTIAL OR COMPLETE BOWEL OBSTRUCTION
☐ REFLEX DISTURBANCES
☐ PAIN
☐ NAUSEA
☐ VOMITING
☐ ABDOMINAL DISTENTION
☐ CONSTIPATION *(perhaps alternating with diarrhea)*

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

☐ YES ☐ NO LIST MEDICATIONS: _____

SECTION III - SEVERITY OF MANIFESTATIONS OF PERITONEAL ADHESIONS

NOTE - Indicate level of severity of signs and/or symptoms, if present: *(Check all that apply in each level)*

3A. LEVEL IV

☐ SEVERE ☐ DEFINITE PARTIAL OBSTRUCTION SHOWN BY X-RAY ☐ FREQUENT EPISODES OF SEVERE COLIC DISTENSION ☐ FREQUENT EPISODES OF SEVERE NAUSEA ☐ FREQUENT EPISODES OF SEVERE VOMITING

☐ PROLONGED EPISODES OF SEVERE COLIC DISTENSION ☐ PROLONGED EPISODES OF SEVERE NAUSEA ☐ PROLONGED EPISODES OF SEVERE VOMITING

3B. LEVEL III

☐ MODERATELY SEVERE ☐ PARTIAL OBSTRUCTION MANIFESTED BY DELAYED MOTILITY OF BARIUM MEAL ☐ LESS FREQUENT EPISODES OF PAIN ☐ LESS PROLONGED EPISODES OF PAIN

3C. LEVEL II

☐ MODERATE ☐ PULLING PAIN ON ATTEMPTING WORK OR AGGRAVATED BY MOVEMENTS OF THE BODY ☐ OCCASIONAL EPISODES OF COLIC PAIN ☐ OCCASIONAL EPISODES OF NAUSEA ☐ OCCASIONAL EPISODES OF CONSTIPATION *(Perhaps alternating with diarrhea)* ☐ ABDOMINAL DISTENSION

3D. LEVEL I

☐ MILD, DESCRIBE: _____

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

4A. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO IF YES, ARE ANY OF THE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE cm *(6 square inches)* OR ARE LOCATED ON THE HEAD, FACE OR NECK?

☐ YES ☐ NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE.
IF NO, PROVIDE LOCATION AND MEASURMENTS OF SCAR IN CENTIMETERS.

LOCATION: _____

MEASUREMENTS: Length _____ cm X width _____ cm.

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the Remarks section below. It is not necessary to also complete a Scars DBQ.

4B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO *(If "Yes," describe - brief summary):*

SECTION V - DIAGNOSTIC TESTING

5. HAS THE VETERAN HAD LABORATORY OR OTHER DIAGNOSTIC STUDIES PERFORMED AND ARE THE RESULTS AVAILABLE?

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

SECTION VI - FUNCTIONAL IMPACT

6. BASED ON YOUR EXAMINATION AND/OR THE VETERAN'S HISTORY, DOES THE VETERAN'S PERITONEAL ADHESION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the veteran's peritoneal adhesions, providing one or more examples)*

SECTION VII - REMARKS

7. REMARKS *(If any)*

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE AND FAX NUMBER	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. 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.