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

Department of Veterans Affairs

INFECTIOUS INTESTINAL DISORDERS, INCLUDING BACTERIAL AND PARASITIC INFECTIONS 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 AN INFECTIOUS INTESTINAL CONDITION?

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

☐ BACILLARY DYSENTERY ICD code: _____ Date of diagnosis: _____

☐ INTESTINAL DISTOMIASIS *(intestinal fluke)* ICD code: _____ Date of diagnosis: _____

☐ PARASITIC INFECTION OF THE INTESTINES ICD code: _____ Date of diagnosis: _____

☐ AMEBIASIS ICD code: _____ Date of diagnosis: _____

NOTE: If the veteran has a lung abscess due to amebiasis, ALSO complete VA Form 21-0960L-1, Respiratory Conditions Disability Benefits Questionnaire.

☐ OTHER INFECTIOUS INTESTINAL CONDITION

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 INTESTINAL CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset, course, and past treatment)* OF THE VETERAN'S INFECTIOUS INTESTINAL CONDITIONS *(brief summary)*:

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

☐ YES ☐ NO IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR THE INTESTINAL CONDITIONS:

2C. HAS THE VETERAN HAD SURGICAL TREATMENT FOR AN INTESTINAL CONDITION?

☐ YES ☐ NO *(If "Yes," ALSO complete VA Form 21-0960G-4, Intestinal Surgery (Bowel Resection, Colostomy, Ileostomy) Disability Benefits Questionnaire)*

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY INFECTIOUS INTESTINAL CONDITIONS?

☐ YES ☐ NO IF YES, CHECK ALL THAT APPLY

☐ MILD SYMPTOMS ATTRIBUTABLE TO DISTOMIASIS, INTESTINAL OR HEPATIC *(If checked, describe)*: _____

☐ MODERATE SYMPTOMS ATTRIBUTABLE TO DISTOMIASIS, INTESTINAL OR HEPATIC *(If checked, describe)*: _____

☐ SEVERE SYMPTOMS ATTRIBUTABLE TO DISTOMIASIS, INTESTINAL OR HEPATIC *(If checked, describe)*: _____

☐ MILD GASTROINTESTINAL DISTURBANCES *(If checked, describe)*: _____

☐ LOWER ABDOMINAL CRAMPS. *If checked, describe*: _____

☐ GASEOUS DISTENTION *(If checked, describe)*: _____

☐ CHRONIC CONSTIPATION INTERRUPTED BY DIARRHEA *(If checked, describe)*: _____

☐ ANEMIA (If checked, provide hemoglobin/hematocrit in Section 8, Diagnostic Testing)

☐ NAUSEA *(If checked, describe)*: _____

☐ VOMITING *(If checked, describe)*: _____

☐ OTHER, *(describe)*: _____

NOTE - Complete the appropriate Disability Benefits Questionnaire(s) when the infectious disease affects other organs such as the liver, lung, kidney, etc. (schedule with appropriate provider).

SECTION IV - SYMPTOM EPISODES, ATTACKS AND EXACERBATIONS

4. DOES THE VETERAN HAVE EPISODES OF BOWEL DISTURBANCE WITH ABDOMINAL DISTRESS, OR EXACERBATIONS OR ATTACKS OF THE INTESTINAL CONDITION?

☐ YES ☐ NO IF YES, INDICATE SEVERITY AND FREQUENCY *(check all that apply)*

☐ EPISODES OF BOWEL DISTURBANCE WITH ABDOMINAL DISTRESS. IF CHECKED, INDICATE FREQUENCY:

☐ Occasional episodes ☐ Frequent episodes ☐ More or less constant abdominal distress

☐ EPISODES OF EXACERBATIONS AND/OR ATTACKS OF THE INTESTINAL CONDITION
IF CHECKED, DESCRIBE TYPICAL EXACERBATION OR ATTACK: _____

INDICATE NUMBER OF EXACERBATIONS AND/OR ATTACKS IN PAST 12 MONTHS:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

SECTION V - WEIGHT LOSS

5. DOES THE VETERAN HAVE WEIGHT LOSS ATTRIBUTABLE TO AN INFECTIOUS INTESTINAL CONDITION?

☐ YES ☐ NO

IF YES, PROVIDE VETERAN'S BASELINE WEIGHT: _____ AND CURRENT WEIGHT: _____

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

SECTION VI - MALNUTRITION, COMPLICATIONS AND OTHER GENERAL HEALTH EFFECTS

6. DOES THE VETERAN HAVE MALNUTRITION, SERIOUS COMPLICATIONS OR OTHER GENERAL HEALTH EFFECTS ATTRIBUTABLE TO THE INTESTINAL CONDITION?

☐ YES ☐ NO IF YES, INDICATE SEVERITY *(check all that apply)*

☐ Health only fair during remissions

☐ Resulting in general debility

☐ Serious complication such as liver abscess *(Describe)* _____

☐ Malnutrition. If checked, is malnutrition marked? ☐ Yes ☐ No

☐ Other (*Describe*):

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

7A. 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.

7B. 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 VIII - DIAGNOSTIC TESTING

NOTE: If imaging studies, diagnostic procedures or laboratory testing have been performed and reflect the veteran's current condition, provide most recent results; no further studies or testing are required for this examination.

8A. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ CBC *(if anemia due to any intestinal condition is suspected or present)*

Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

☐ Other, specify: _____

Date of test: _____

Results: _____

8B. HAVE IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

8C. 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 IX - FUNCTIONAL IMPACT

9. DO ANY OF THE VETERAN'S INFECTIOUS INTESTINAL CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S INFECTIOUS INTESTINAL CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION X - REMARKS

10. REMARKS, IF ANY:

SECTION XI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

11A. PHYSICIAN'S SIGNATURE	11B. PHYSICIAN'S PRINTED NAME	11C. DATE SIGNED

11D. PHYSICIAN'S PHONE AND FAX NUMBER	11E. PHYSICIAN'S MEDICAL LICENSE NUMBER	11F. 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.