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

Department of Veterans Affairs

NON-DEGENERATIVE ARTHRITIS (INCLUDING INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE AND INFECTIOUS ARTHRITIS) AND DYSBARIC OSTEONECROSIS 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 ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - The veteran or service member 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 claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

MEDICAL RECORD REVIEW

WAS THE VETERAN'S VA CLAIMS FILE REVIEWED?

☐ YES ☐ NO

IF YES, LIST ANY RECORDS THAT WERE REVIEWED BUT WERE NOT INCLUDED IN THE VETERAN'S VA CLAIMS FILE:

IF NO, CHECK ALL RECORDS REVIEWED:

- ☐ Military service treatment records
- ☐ Military service personnel records
- ☐ Military enlistment examination
- ☐ Military separation examination
- ☐ Military post-deployment questionnaire
- ☐ Department of Defense Form 214 Separation Documents
- ☐ Veterans Health Administration medical records *(VA treatment records)*
- ☐ Civilian medical records
- ☐ Interviews with collateral witnesses *(family and others who have known the veteran before and after military service)*
- ☐ Other: _____
- ☐ No records were reviewed

NOTE: Complete this Questionnaire if the Veteran has an inflammatory, autoimmune, crystalline or infectious arthritis, or dysbaric osteonecrosis (Caisson disease of bone).

If the Veteran has degenerative arthritis (osteoarthritis) or traumatic arthritis, do not complete this Questionnaire, INSTEAD complete the joint Questionnaire for the affected area (e.g., if the diagnosis is osteoarthritis of the knee, complete the Knee Questionnaire).

If the Veteran has arthritis due to systemic lupus erythematosus (SLE), instead complete the SLE Questionnaire.

SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS DBQ:

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. 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 comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) *(Check all that apply)*:

- ☐ The Veteran does not have a current diagnosis associated with any claimed condition listed above. *(Explain your findings and reasons in comments section.)*
- ☐ Gout — ICD Code: _____ Date of diagnosis: _____
- ☐ Rheumatoid arthritis *(atrophic)* — ICD Code: _____ Date of diagnosis: _____
- ☐ Gonorrheal arthritis — ICD Code: _____ Date of diagnosis: _____
- ☐ Pneumococcic arthritis — ICD Code: _____ Date of diagnosis: _____
- ☐ Typhoid arthritis — ICD Code: _____ Date of diagnosis: _____
- ☐ Syphilitic arthritis — ICD Code: _____ Date of diagnosis: _____
- ☐ Streptococcic arthritis — ICD Code: _____ Date of diagnosis: _____
- ☐ Dysbaric osteonecrosis *(Caisson Disease of Bone)* — ICD Code: _____ Date of diagnosis: _____
- ☐ Other *(specify) (If checked, provide only diagnoses that pertain to inflammatory, autoimmune, crystalline or infectious arthritis.)*

Other diagnosis #1: _____ ICD Code: _____ Date of diagnosis: _____

Other diagnosis #2: _____ ICD Code: _____ Date of diagnosis: _____

Other diagnosis #3: _____ ICD Code: _____ Date of diagnosis: _____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION I - DIAGNOSIS *(Continued)*

1C. COMMENTS *(if any):*

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION *(internal VA only)*?

☐ YES ☐ NO ☐ N/A IF YES, INCLUDE MEDICAL OPINION DBQ.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS OR DYSBARIC OSTEONECROSIS *(brief summary):*

2B. DOES THE VETERAN REQUIRE CONTINUOUS USE OF MEDICATION FOR THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THIS ARTHRITIS:

2C. HAS THE VETERAN LOST WEIGHT DUE TO THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, PROVIDE BASELINE WEIGHT *(average weight for 2-year period preceding onset of disease):* _____ , AND CURRENT WEIGHT _____

IF YES, DOES THE VETERAN'S WEIGHT LOSS ATTRIBUTABLE TO THE ARTHRITIS CONDITION CAUSE IMPAIRMENT OF HEALTH?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPAIRMENT:

2D. DOES THE VETERAN HAVE ANEMIA DUE TO THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, DOES THE VETERAN'S ANEMIA ATTRIBUTABLE TO THE ARTHRITIS CONDITION CAUSE IMPAIRMENT OF HEALTH?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPAIRMENT *(also provide CBC under diagnostic testing section #9):*

SECTION III - JOINT INVOLVEMENT

3A. DOES THE VETERAN HAVE PAIN *(with or without joint movement)* ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, INDICATE AFFECTED JOINTS *(check all that apply):*

☐ CERVICAL SPINE ☐ THORACOLUMBAR SPINE ☐ SACROILIAC JOINTS

RIGHT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

LEFT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

FOR ALL CHECKED JOINTS, DESCRIBE INVOLVEMENT *(brief summary)*:

3B. DOES THE VETERAN HAVE ANY LIMITATION OF JOINT MOVEMENT ATTRIBUTABLE TO THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, INDICATE AFFECTED JOINTS *(check all that apply):*

☐ CERVICAL SPINE ☐ THORACOLUMBAR SPINE ☐ SACROILIAC JOINTS

RIGHT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

LEFT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

FOR ALL CHECKED JOINTS, DESCRIBE LIMITATION OF MOVEMENT *(brief summary):*

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III - JOINT INVOLVEMENT *(Continued)*

3C. DOES THE VETERAN HAVE ANY JOINT DEFORMITIES ATTRIBUTABLE TO THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, INDICATE AFFECTED JOINTS *(check all that apply):*

☐ CERVICAL SPINE ☐ THORACOLUMBAR SPINE ☐ SACROILIAC JOINTS

RIGHT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

LEFT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

FOR ALL CHECKED JOINTS, DESCRIBE DEFORMITIES *(brief summary)*:

3D. COMMENTS *(if any):*

NOTE: For pain, limitation of joint movement and joint deformities, ALSO complete the appropriate DBQ for each affected joint, if indicated. ALSO complete the appropriate DBQ for each affected system, if indicated.

SECTION IV - SYSTEMIC INVOLVEMENT OTHER THAN JOINTS

4A. DOES THE VETERAN HAVE ANY INVOLVEMENT OF ANY SYSTEMS, OTHER THAN JOINTS, ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, INDICATE SYSTEMS INVOLVED *(check all that apply):*

☐ OPHTHALMOLOGICAL ☐ SKIN AND MUCOUS MEMBRANES ☐ HEMATOLOGIC ☐ PULMONARY ☐ CARDIAC

☐ NEUROLOGIC ☐ RENAL ☐ GASTROINTESTINAL ☐ VASCULAR

FOR ALL CHECKED SYSTEMS, DESCRIBE INVOLVEMENT *(brief summary) (Also complete the appropriate DBQ for each affected system, if indicated)*:

4B. COMMENTS *(if any):*

SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS

5A. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE EXACERBATIONS WHICH ARE NOT INCAPACITATING?

☐ YES ☐ NO

IF YES, INDICATE FREQUENCY OF NON-INCAPACITATING EXACERBATIONS PER YEAR:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 OR MORE

Date of most recent non-incapacitating exacerbation: _____

Duration of most recent non-incapacitating exacerbation: _____

Describe non-incapacitating exacerbation: _____

5B. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE EXACERBATIONS WHICH ARE INCAPACITATING?

☐ YES ☐ NO

IF YES, INDICATE FREQUENCY OF INCAPACITATING EXACERBATIONS PER YEAR *(on average):*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 OR MORE

INDICATE THE TOTAL DURATION OF INCAPACITATION OVER THE PAST 12 MONTHS:

☐ < 1 WEEK

☐ 1 WEEK TO < 2 WEEKS

☐ 2 WEEKS TO < 4 WEEKS

☐ 4 WEEKS TO < 6 WEEKS

☐ 6 WEEKS OR MORE

Date of most recent incapacitating exacerbation: _____

Duration of most recent incapacitating exacerbation: _____

Describe incapacitating exacerbation: _____

5C. IS THE VETERAN'S ARTHRITIS MANIFESTED BY CONSTITUTIONAL MANIFESTATIONS ASSOCIATED WITH ACTIVE JOINT INVOLVEMENT WHICH ARE TOTALLY INCAPACITATING?

☐ YES ☐ NO

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SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS *(Continued)*

5D. IS THE VETERAN'S ARTHRITIS MANIFESTED BY WEIGHT LOSS AND ANEMIA PRODUCTIVE OF SEVERE IMPAIRMENT OF HEALTH?

☐ YES ☐ NO

5E. IS THE VETERAN'S ARTHRITIS MANIFESTED BY SEVERELY INCAPACITATING EXACERBATIONS OCCURRING 4 OR MORE TIMES A YEAR OR A LESSER NUMBER OVER PROLONGED PERIODS?

☐ YES ☐ NO

5F. IS THE VETERAN'S ARTHRITIS MANIFESTED BY SYMPTOM COMBINATIONS PRODUCTIVE OF DEFINITE IMPAIRMENT OF HEALTH OBJECTIVELY SUPPORTED BY EXAMINATION FINDINGS?

☐ YES ☐ NO

5G. COMMENTS *(if any):*

SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

6A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS, OR ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO IF YES, COMPLETE QUESTIONS 6B-6D.

6B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO IF YES, DESCRIBE *(brief summary)*:

6C. 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 ABOVE?

☐ YES ☐ NO

IF YES, ARE ANY OF THESE 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.

IF NO, PROVIDE LOCATION AND MEASUREMENTS 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 Comment section below. It is not necessary to also complete a Scars DBQ.

6D. COMMENTS, IF ANY:

SECTION VII - ASSISTIVE DEVICES

7A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

☐ YES ☐ NO IF YES, IDENTIFY ASSISTIVE DEVICES USED *(check all that apply and indicate frequency):*

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutches	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

7B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

8. DUE TO THE VETERAN'S ARTHRITIS CONDITION, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)*

☐ YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROTHESIS WOULD EQUALLY SERVE THE VETERAN.

☐ NO

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES: ☐ RIGHT UPPER ☐ LEFT UPPER ☐ RIGHT LOWER ☐ LEFT LOWER

FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES *(brief summary)*:

NOTE: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prothesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

SECTION IX - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition.

9A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, INDICATE TYPE OF STUDY:

☐ X-RAY Area(s) imaged: _____ Date: _____ Results: _____

☐ OTHER, SPECIFY: _____

Area(s) imaged: _____ Date: _____ Results: _____

9B. HAVE LABORATORY STUDIES BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

IF ANY TEST RESULTS IN THIS SECTION *(Section B)* ARE OTHER THAN NORMAL, INCLUDE NORMAL REFERENCE RANGES FOR YOUR FACILITY.

☐ ERYTHROCYTE SEDIMENTATION RATE *(ESR)* Date of test: _____ Results: _____

☐ C-REACTIVE PROTEIN Date of test: _____ Results: _____

☐ RHEUMATOID FACTOR *(RF)* Date of test: _____ Results: _____

☐ ANTI-DNA ANTIBODIES Date of test: _____ Results: _____

☐ ANTINUCLEAR ANTIBODIES *(ANA)* Date of test: _____ Results: _____

☐ ANTI-CYCLIC CITRULLINATED PEPTIDE (ANTI-CCP) ANTIBODIES Date of test: _____ Results: _____

☐ CBC Date of test: _____

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

☐ URIC ACID TEST Date of test: _____ Results: _____

☐ OTHER, SPECIFY: _____ Date of test: _____ Results: _____

9C. HAS THE VETERAN HAD A JOINT ASPIRATION OR SYNOVIAL FLUID ANALYSIS?

☐ YES ☐ NO

IF YES, INDICATE JOINT ASPIRATED, DATE AND RESULTS:

9D. HAS THE VETERAN HAD A BIOPSY *(e.g., skin, nerve, fat, rectum, kidney)?*

☐ YES ☐ NO

IF YES, INDICATE AREA BIOPSIED, DATE AND RESULTS:

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):*

9F. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION X - FUNCTIONAL IMPACT

NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

10. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK *(such as standing, walking, lifting, sitting, etc.)*?

☐ YES ☐ NO IF YES, DESCRIBE THE FUNCTIONAL IMPACT OF EACH CONDITION, PROVIDING ONE OR MORE EXAMPLES:

SECTION XI - REMARKS

11. REMARKS, IF ANY:

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. NATIONAL PROVIDER IDENTIFIER (NPI) 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.vba.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 required to obtain or retain benefits. 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.