Department of Veterans Affairs

INTESTINAL CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran	Patient/Veteran's Social Security Number	Date of examination:

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.

Note - The Veteran 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 may obtain additional medical information, including an examination, if necessary, to complete VA's review of the Veteran's application. VA reserves the right to confirm the authenticity of ALL completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on the 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 questionnaire:

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(s), 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 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(s) listed above. (Explain your findings and reasons in the remarks section)

☐ Irritable bowel syndrome ICD Code: _____ Date of diagnosis: _____

If checked, complete Section III

☐ Functional digestive disorder(s) (if checked, specify in text box below)

If checked, complete Section III and Section XII

Note: Functional digestive disorders include, but are not limited to functional dyspepsia, functional bloating, functional diarrhea, functional constipation, functional abdominal pain syndrome, and functional vomiting. If the functional digestive disorder affects the esophagus also complete Esophageal Conditions Questionnaire.

_____ ICD Code: _____ Date of diagnosis: _____

☐ Inflammatory bowel disease (select from below):

If checked, complete Section IV

☐ Ulcerative colitis ICD Code: _____ Date of diagnosis: _____

☐ Crohn's disease ICD Code: _____ Date of diagnosis: _____

☐ Undifferentiated form of inflammatory bowel disease ICD Code: _____ Date of diagnosis: _____

☐ Chronic enteritis ICD Code: _____ Date of diagnosis: _____

If checked, complete Section III and Section IV

☐ Diverticular disease (select from below)

If checked, complete Section V

☐ Diverticulitis ICD Code: _____ Date of diagnosis: _____

☐ Diverticulosis ICD Code: _____ Date of diagnosis: _____

☐ Chronic complications of small intestine surgery (without resection) (including bariatric surgery) (if checked, specify):

If checked, complete Section VI and Section VII

_____ ICD Code: _____ Date of diagnosis: _____

☐ Resection of small intestine (select one if known) ICD Code: _____ Date of diagnosis: _____

If checked, complete Section VI and Section VIII

☐ Short bowel syndrome ICD Code: _____ Date of diagnosis: _____

☐ Mesenteric ischemic thrombosis ICD Code: _____ Date of diagnosis: _____

☐ Post-bariatric surgery ICD Code: _____ Date of diagnosis: _____

☐ Resection of large intestine ICD Code: _____ Date of diagnosis: _____

If checked, complete Section VI and Section IX

☐ External intestinal fistulous disease ICD Code: _____ Date of diagnosis: _____

If checked, complete Section X

☐ Celiac disease ICD Code: _____ Date of diagnosis: _____

If checked, complete Section VIII and Section XI

☐ Gastrointestinal dysmotility syndrome ICD Code: _____ Date of diagnosis: _____

If checked, complete Section XII

☐ Visceroptosis (downward displacement of the abdominal viscera) ICD Code: _____ Date of diagnosis: _____

If checked, complete Section XIII

☐ Malignant intestinal neoplasm (if checked, specify):

If checked, complete Section XIV

_____ ICD Code: _____ Date of diagnosis: _____

☐ Benign intestinal neoplasm (if checked, specify):

If checked, complete Section XIV

_____ ICD Code: _____ Date of diagnosis: _____

☐ Peritoneal adhesions ICD Code: _____ Date of diagnosis: _____

If checked, complete Peritoneal Adhesions questionnaire

☐ Other intestine condition(s) (if checked, specify):

If checked, complete the section(s) that best approximates the disability picture

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 intestine conditions, list using above format and complete the section(s) that best approximates the disability picture:

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's intestine condition(s). Brief summary:

2B. Does the Veteran's treatment plan include taking daily prescribed medication for the diagnosed condition(s)?

◯ Yes ◯ No

If yes, list only those medications used for the diagnosed condition(s):

SECTION III - IRRITABLE BOWEL SYNDROME

3A. Does the Veteran have irritable bowel syndrome, chronic enteritis, functional digestive disorder, or a similar condition?

◯ Yes ◯ No If yes, complete 3B and 3C:

3B. Frequency of abdominal pain related to defecation during the previous 3 months:

◯ None ◯ At least once ◯ At least 3 days per month ◯ At least 1 day per week

3C. Signs or symptoms (check all that apply):

☐ Change in stool frequency ☐ Change in stool form ☐ Altered stool passage (straining and/or urgency) ☐ Mucorrhea

☐ Abdominal bloating ☐ Subjective distention ☐ Other, specify: _____

SECTION IV - INFLAMMATORY BOWEL DISEASE

Note: A diagnosis of inflammatory bowel disease must be confirmed by endoscopy or radiologic studies (discuss findings in Section XVI).

4A. Does the Veteran have Crohn's disease, ulcerative colitis, undifferentiated form of inflammatory bowel disease, chronic enteritis, or a similar condition?

◯ Yes ◯ No If yes, check all that apply:

☐ Managed with oral or topical agents (other than immunosuppressants or other biologic agents (if checked, list medication(s)):

_____

☐ Managed on an outpatient basis with immunosuppressants or other biologic agents (if checked, list medication(s)):

_____

☐ Unresponsive to treatment

☐ Requires hospitalization at least once per year (if checked, give date and name of hospital for each recent hospitalization if known):

_____

☐ Results in an inability to work (if checked, discuss how condition impacts ability to work):

_____

☐ Recurrent abdominal pain

☐ Daily diarrhea (if checked, indicate frequency):

◯ 3 or less episodes ◯ 4-5 episodes ◯ 6 or more episodes

☐ No signs of systemic toxicity (such as fever, tachycardia, or anemia)

☐ Signs of toxicity such as fever, tachycardia, or anemia (Check all that apply):

☐ Minimal ☐ Intermittent

☐ Fever ☐ Tachycardia ☐ Anemia ☐ Other, specify: _____

☐ Recurrent abdominal distention

☐ Recurrent episodes of rectal incontinence

☐ Six or more episodes per day of rectal bleeding

☐ Resulting in colectomy or colostomy (also complete Section VI and Section IX)

☐ Peritoneal adhesions (also complete Peritoneal Adhesions questionnaire)

☐ Other, specify: _____

SECTION V - DIVERTICULAR DISEASE

5A. Does the Veteran have diverticular disease or a similar condition?

◯ Yes ◯ No If yes, check all that apply:

☐ Asymptomatic

☐ Managed by diet and medication

☐ Diverticular disease requiring hospitalization one or more times in the past 12 months (if checked, give date(s) and name of hospital(s) if known):

_____

Indicate reason(s) for hospitalization below, check all that apply:

☐ Abdominal distress ☐ Fever ☐ Leukocytosis (elevated white blood cells) ☐ Other, specify: _____

☐ Diverticular disease complications (check all that apply):

☐ Hemorrhage ☐ Obstruction ☐ Abscess

☐ Peritonitis ☐ Perforation ☐ Other, specify: _____

☐ Peritoneal adhesions (also complete Peritoneal Adhesions questionnaire)

☐ Resulting in colectomy or colostomy (also complete Section VI and Section IX)

SECTION VI - SURGICAL PROCEDURE(S)

6A. Did the Veteran have surgery for an intestinal condition(s) (including bariatric surgery)? (If yes, give surgery type(s) and date(s))

◯ Yes ◯ No

Surgery type: _____ Surgery date: _____

Surgery type: _____ Surgery date: _____

SECTION VII - CHRONIC COMPLICATIONS OF SMALL INTESTINE SURGERY (WITHOUT RESECTION)

7A. Does the Veteran have chronic complications of small intestine surgery (without resection) (including bariatric surgery)?

◯ Yes ◯ No If yes, check all that apply (if appropriate):

☐ Post-operative, asymptomatic

☐ Requiring continuous total parenteral nutrition (TPN) for a period longer than 30 consecutive days in the last six months.

If checked, list dates: Start date of TPN: _____ Completion date of TPN or anticipated date of completion: _____

☐ Requiring continuous tube feeding for a period longer than 30 consecutive days in the last six months.

If checked, list dates: Start date of tube feeding: _____ Completion date of tube feeding or anticipated date of completion: _____

☐ Vomiting (if checked, indicate frequency and if managed by medical treatment, oral dietary modification, or medication):

Frequency:

◯ Less than 2 times a week ◯ 2 or more times a week ◯ Daily

Treatment:

◯ No treatment

◯ Managed by ongoing medical treatment

◯ Vomiting despite medical treatment (check all that apply)

☐ Oral dietary modification

☐ Medication

☐ Other (specify): _____

☐ Watery bowel movements (if checked, indicate frequency):

◯ Less than 3 per day every day ◯ 3-5 per day every day ◯ 6 or more per day every day

☐ Explosive bowel movements that are difficult to predict or control

☐ Nausea (if checked, indicate if managed by medical treatment):

Managed by ongoing medical treatment? ◯ Yes ◯ No

☐ Post-prandial (meal-induced) light-headedness (syncope) with sweating

☐ Requirement for medications to specifically treat complications of upper GI surgery including dumping syndrome or delayed gastric emptying

☐ Peritoneal adhesions (Also complete Peritoneal Adhesions questionnaire)

☐ Discomfort or pain within an hour of eating and requiring ongoing oral dietary modification

☐ Other symptoms, specify: _____

SECTION VIII - RESECTION OF SMALL INTESTINE

Note: "Undernutrition" means a deficiency resulting from insufficient intake of one or multiple essential nutrients, or the inability of the body to absorb, utilize, or retain such nutrients. Undernutrition is characterized by failure of the body to maintain normal organ functions and healthy tissues. Signs and symptoms may include: loss of subcutaneous tissue, edema, peripheral neuropathy, muscle wasting, weakness, abdominal distention, ascites, and Body Mass Index below normal range.

8A. Did the Veteran have resection of the small intestine (including bariatric surgery, short bowel syndrome, or mesenteric ischemic thrombosis) or currently have celiac disease with malabsorption?

◯ Yes ◯ No If yes, check all that apply:

Note: If the Veteran currently has celiac disease with malabsorption, check the symptoms related to celiac disease regardless of whether the Veteran has undergone a resection of the small intestine.

☐ Status post resection, asymptomatic

☐ Four or more episodes of diarrhea per day

☐ Undernutrition (see note above)

☐ Anemia

☐ Requiring continuous medication

☐ Requiring prescribed oral dietary supplementation

☐ Requiring total parenteral nutrition (TPN) (If checked, indicate frequency):

◯ Intermittent ◯ Continuous

☐ Short bowel syndrome that results in high-output syndrome, to include a high-output stoma (also complete Section IX)

☐ Peritoneal adhesions (also complete appropriate Peritoneal Adhesions questionnaire)

☐ Other symptoms, specify: _____

SECTION IX - RESECTION OF LARGE INTESTINE

9A. Did the Veteran have resection of the large intestine and/or resection of the small intestine with short bowel syndrome that results in high-output syndrome, to include a high-output stoma?

◯ Yes ◯ No If yes, check all that apply:

☐ Colectomy (if checked, indicate if partial or total):

◯ Partial ◯ Total

☐ Permanent colostomy

☐ Reanastomosis (reconnection of the intestinal tube)

☐ Loss of ileocecal valve

☐ Recurrent episodes of diarrhea (if checked, indicate frequency):

◯ Less than 4 times per day ◯ 4 or more times per day

☐ Without high-output syndrome

☐ With high-output syndrome

☐ Formation of ileostomy

☐ More than 2 episodes of dehydration requiring intravenous hydration in the past 12 months (if checked, provide dates and location(s) if known):

_____

☐ Peritoneal adhesions (also complete Peritoneal Adhesions questionnaire)

☐ Other symptoms, specify: _____

SECTION X - EXTERNAL INTESTINAL FISTULOUS DISEASE

Note: External intestinal fistulous disease applies to external fistulas that have developed as a consequence of abdominal trauma, surgery, radiation, malignancy, infection or ischemia.

10A. Does the Veteran have external intestinal fistulous disease?

◯ Yes ◯ No If yes, check all that apply:

☐ Intermittent fecal discharge

☐ Persistent drainage in the past 12 months (if checked, indicate frequency):

◯ more than 1 month ◯ more than 2 months ◯ more than 3 months

☐ Daily discharge (if checked, indicate volume):

◯ Equivalent to 3 or less ostomy bags (130 cc) ◯ Equivalent to 4 or more ostomy bags (130 cc)

☐ Requiring pad changes (if checked, indicate frequency):

◯ Fewer than 10 pad changes per day ◯ 10 or more pad changes per day

☐ Body Mass Index (BMI) of 16 to 18 inclusive

☐ BMI of less than 16

☐ Requiring enteral nutrition (tube feeding)

☐ Requiring total parenteral nutrition (TPN)

☐ Other symptoms, specify: _____

SECTION XI - CELIAC DISEASE

Note: An appropriate serum antibody test or endoscopy with biopsy must confirm a diagnosis of celiac disease (discuss findings in Section XVI).

11A. Does the Veteran have celiac disease or a similar condition?

◯ Yes ◯ No If yes, check all that apply:

☐ Asymptomatic

☐ Malabsorption syndrome that causes chronic diarrhea managed by medically-prescribed dietary intervention such as prescribed gluten-free diet

☐ Malabsorption syndrome that causes weakness which interferes with activities of daily living (if checked, discuss how weakness interferes with activities of daily living):

_____

☐ Without nutritional deficiencies

☐ With nutritional deficiencies due to lactase and pancreatic insufficiency

☐ Episodes of abdominal pain and diarrhea due to lactase or pancreatic insufficiency

☐ Systemic manifestations (check all that apply):

☐ Weakness and fatigue ☐ Dermatitis ☐ Lymph node enlargement

☐ Hypocalcemia ☐ Low vitamin levels ☐ Other, specify: _____

☐ Atrophy of the inner intestinal lining shown on biopsy (discuss biopsy in Section XVI)

☐ Weight loss resulting in wasting and nutritional deficiencies

☐ Anemia related to malabsorption

☐ Other symptoms, specify: _____

SECTION XII - GASTROINTESTINAL DYSMOTILITY SYNDROME

12A. Does the Veteran have gastrointestinal dysmotility syndrome, functional digestive disorder, or a similar condition?

◯ Yes ◯ No If yes, check all that apply:

☐ Without evidence of structural gastrointestinal disease

☐ With symptoms of intestinal dysmotility disorder (check all that apply):

☐ Abdominal pain (if checked, indicate if intermittent below):

☐ Intermittent

☐ Feeling of epigastric fullness

☐ Bloating

☐ Dyspepsia

☐ Nausea (if checked, indicate if recurrent below):

☐ Recurrent

☐ Vomiting (if checked, indicate if recurrent below):

☐ Recurrent

☐ Regurgitation

☐ Constipation

☐ Diarrhea

☐ Other symptom(s) of intestinal dysmotility disorder (specify): _____

☐ Symptoms of chronic intestinal pseudo-obstruction (CIPO) (specify): _____

☐ Treatment (check all that apply):

☐ Symptoms managed by ambulatory care

☐ Requiring prescribed dietary management or manipulation

☐ Recurrent emergency treatment for episodes of intestinal obstruction or regurgitation due to poor gastric emptying, abdominal pain, recurrent nausea, or recurrent vomiting

If checked, provide date(s) and location(s) if known:

_____

☐ Requiring tube feeding for nutritional support (if checked, indicate if intermittent or continuous):

◯ Intermittent ◯ Continuous

☐ Requiring complete dependence on total parenteral nutrition (TPN)

SECTION XIII- VISCEROPTOSIS

13A. Does the Veteran have visceroptosis?

◯ Yes ◯ No If yes, indicate if asymptomatic or symptomatic:

◯ Asymptomatic ◯ Symptomatic

Identify symptoms below:

_____

13B. Is the visceroptosis marked?

◯ Yes ◯ No

SECTION XIV - TUMORS AND NEOPLASMS

14A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

◯ Yes ◯ No If yes, complete the following section.

14B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

◯ Primary ◯ Secondary (metastatic) (if secondary, indicate the primary site, if known): _____

14C. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

◯ Yes ◯ No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

☐ Treatment completed

☐ Surgery

If checked, describe: _____

Date(s) of surgery: _____

☐ Radiation therapy

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

☐ Antineoplastic chemotherapy

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: _____

14D. Does the Veteran currently have any residuals or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

◯ Yes ◯ No

If yes, list residuals or complications (brief summary), and also complete the appropriate questionnaire:

14E. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the above format:

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

15A. 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):

15B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?

◯ Yes ◯ No If yes, also complete the appropriate dermatological questionnaire.

SECTION XVI - DIAGNOSTIC TESTING

Note: If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report. A diagnosis of inflammatory bowel disease must be confirmed by endoscopy or radiologic studies. A diagnosis of celiac disease must be confirmed by serum antibody test or endoscopy with biopsy.

16A. Have clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, check all that apply:

☐ Endoscopy

Date: _____ Results: _____

☐ Radiographic study(ies)

☐ MRI

Date: _____ Results: _____

☐ Computed tomography (CT) scan

Date: _____ Results: _____

☐ Other radiographic study, specify: _____

Date: _____ Results: _____

☐ Biopsy, specify site:

Date: _____ Results: _____

☐ Other diagnostic test, specify: _____

Date: _____ Results: _____

16B. Has clinically relevant laboratory testing been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, check all that apply:

☐ CBC Date of test: _____

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

☐ Serum antibody test, specify: _____ Date of test: _____ Results: _____

☐ Other lab test, specify: _____ Date of test: _____ Results: _____

16C. Are there any other clinically relevant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, provide type of test or procedure, date and results (brief summary):

16D. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed condition.

SECTION XVII - 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.

17A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/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 XVIII - REMARKS

18A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XIX - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

19A. Examiner's signature:	19B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):
19C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	19D. Date Signed:
19E. Examiner's phone/fax numbers:	19F. National Provider Identifier (NPI) number:
19H. Examiner's address:	