Department of Veterans Affairs

HEPATITIS, CIRRHOSIS AND OTHER LIVER 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. Does the Veteran have or has the Veteran ever had a liver condition?

◯ Yes ◯ No (If yes, complete 1C)

1C. Select diagnoses associated with the claimed condition(s) (check all that apply)

☐ Hepatitis A	ICD Code		Date of diagnosis	
☐ Hepatitis B	ICD Code		Date of diagnosis	
☐ Hepatitis C	ICD Code		Date of diagnosis	
☐ Autoimmune hepatitis	ICD Code		Date of diagnosis	
☐ Drug induced hepatitis	ICD Code		Date of diagnosis	
☐ Non-alcoholic steatohepatitis (NASH)	ICD Code		Date of diagnosis	
☐ Cirrhosis of the liver	ICD Code		Date of diagnosis	
☐ Primary sclerosing cholangitis	ICD Code		Date of diagnosis	
☐ Primary biliary cirrhosis	ICD Code		Date of diagnosis	
☐ Liver abscess	ICD Code		Date of diagnosis	
☐ Liver transplant	ICD Code		Date of diagnosis	
☐ Liver cancer	ICD Code		Date of diagnosis	
☐ Hemochromatosis	ICD Code		Date of diagnosis	
☐ Wilson's disease	ICD Code		Date of diagnosis	
☐ Alpha-1 antitrypsin deficiency	ICD Code		Date of diagnosis	
☐ Other liver conditions:				
Other diagnosis #1	ICD Code		Date of diagnosis	
Other diagnosis #2	ICD Code		Date of diagnosis	
Other diagnosis #3	ICD Code		Date of diagnosis	

1D. If there are additional diagnoses that pertain to liver conditions, list using above format:

1E. Remarks:

Note: Determination of these conditions requires documentation by appropriate serologic testing, abnormal liver function tests, and/or abnormal liver biopsy or imaging tests. If test results are documented in the medical record, additional testing is not required.

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's liver condition(s) (brief summary):

SECTION III - CHRONIC LIVER DISEASE WITHOUT CIRRHOSIS (INCLUDING HEPATITIS)

Note 1: Undernutrition: "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.
Note 2: Nutritional Support: The following describe various nutritional support methods used to treat certain digestive conditions.
(1) Total parenteral nutrition or hyperalimentation is a special liquid mixture given into the blood through an intravenous catheter. The mixture contains proteins, carbohydrates (sugars), fats, vitamins, and minerals. Total parenteral nutrition bypasses the normal digestion in the stomach and bowel.
(2) Assisted enteral nutrition requires a special liquid mixture (containing proteins, carbohydrates (sugar), fats, vitamins and minerals) to be delivered into the stomach or bowel through a flexible feeding tube. Percutaneous endoscopic gastrostomy is a type of assisted enteral nutrition in which a flexible feeding tube is inserted through the abdominal wall and into the stomach. Nasogastric or nasoenteral feeding tube is a type of assisted parental nutrition in which a flexible feeding tube is inserted through the nose into the stomach or bowel.

3A. Does the Veteran have or has the Veteran ever had signs or symptoms attributable to chronic or infectious liver disease?

◯ Yes ◯ No

If yes, check all that apply:

☐ Previous history of liver disease

☐ Asymptomatic

☐ Fatigue

If checked, indicate frequency: ◯ Intermittent ◯ Daily

☐ Malaise

☐ Anorexia

☐ Hepatomegaly

☐ Pruritus

☐ Arthralgia

☐ Causing weight loss

If checked, provide baseline weight _____ and current weight _____

Baseline weight means the clinically documented average weight for the two-year period preceding the onset of illness or, if relevant, the weight recorded at the Veteran's most recent discharge physical. If neither of these weights is available or currently relevant, then use ideal body weight as determined by either the Hamwi formula, or Body Mass Index tables, whichever is most favorable to the Veteran.

◯ Substantial weight loss (involuntary loss greater than 20 percent of an individual's baseline weight sustained for three months with diminished quality of self-care or work tasks)

◯ Minor weight loss (involuntary weight loss between 10 and 20 percent of an individual's baseline weight sustained for three months with gastrointestinal-related symptoms, involving diminished quality of self-care or work tasks, or decreased food intake)

☐ Requiring continuous medication (other than parenteral antiviral therapy or parenteral immunomodulatory therapy)

If checked, list medication: _____

If checked, indicate date treatment started: _____ Date of completion of medication or anticipated date of completion: _____

☐ Requiring parenteral antiviral therapy

If checked, indicate date treatment started: _____ Date of completion of medication or anticipated date of completion: _____

☐ Requiring parenteral immunomodulatory therapy

If checked, indicate date treatment started: _____ Date of completion of medication or anticipated date of completion: _____

☐ Other signs or symptoms, describe:

3B. Is treatment medically contraindicated for both parenteral antiviral therapy and parenteral immunomodulatory drugs? If yes, explain. For individuals for whom physicians recommend both parenteral antiviral therapy and parenteral immunomodulatory drugs, but for whom treatment is medically contraindicated, complete section IV.

◯ Yes ◯ No

SECTION IV - CIRRHOSIS OF THE LIVER

Note: Biochemical studies, imaging studies, or biopsy must confirm liver dysfunction (including hyponatremia, thrombocytopenia, and/or coagulopathy).

4A. Does the Veteran have cirrhosis of the liver?

◯ Yes ◯ No

4B. Is treatment medically contraindicated for both parenteral antiviral therapy and parenteral immunomodulatory drugs?

◯ Yes ◯ No

If yes to either 4A or 4B, indicate signs and symptoms (check all that apply):

- ☐ Asymptomatic but with a history of liver disease
- ☐ Resolved following liver transplant
- ☐ Weakness
- ☐ Generalized weakness
- ☐ Malaise
- ☐ Daily fatigue
- ☐ Anorexia
- ☐ Abdominal pain
- ☐ Continuous daily debilitating symptoms (describe in comments section)
- ☐ Splenomegaly
- ☐ Ascites (fluid in the abdomen)
- ☐ Coagulopathy
- ☐ Portal hypertension
- ☐ Portal gastropathy (if checked, date(s) of episode(s) in past 24 months) Date(s): _____
- ☐ Hepatic encephalopathy (if checked, date(s) of episode(s) in past 24 months) Date(s): _____
- ☐ Hepatopulmonary syndrome
- ☐ Hepatorenal syndrome
- ☐ History of spontaneous bacterial peritonitis
- ☐ Variceal hemorrhage (if checked, date(s) of episode(s) in past 24 months) Date(s): _____
- ☐ Other signs or symptoms, describe:

Comments

4C. Is there a MELD score available? If yes, please complete the following:

MELD Score: _____ Date: _____ Source: _____

SECTION V - LIVER ABSCESS

5A. Does the Veteran have or has the Veteran ever had, a liver abscess caused by bacterial, viral, amebic, fungal or other agents?

◯ Yes ◯ No

If yes, what date was the abscess diagnosed? _____

Comments:

If date of initial diagnosis was 6 months or more in the past, also complete appropriate questionnaire(s) to address chronic residuals.

SECTION VI - LIVER TRANSPLANT

6A. Is the Veteran eligible for transplant surgery?

◯ Yes ◯ No Comments:

Date medical evidence shows that a physician determined that the Veteran was eligible for transplant surgery: _____

6B. Is the Veteran awaiting transplant surgery?

◯ Yes ◯ No Comments:

6C. Has the Veteran undergone transplant surgery?

◯ Yes ◯ No

Date(s) of transplant surgery: _____

Date(s) of hospital admission: _____ Date(s) of hospital discharge: _____

Current signs and symptoms:

SECTION VII - DIAGNOSTIC TESTING

Note: If this information is of record, repeat testing is not required. If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

7A. 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:

☐	EUS (Endoscopic ultrasound)	Date:		Results:
☐	ERCP (Endoscopic Retrograde Cholangiopancreatography)	Date:		Results:
☐	Transhepatic cholangiogram	Date:		Results:
☐	MRI or MRCP (Magnetic Resonance Cholangiopancreatography)	Date:		Results:
☐	Computed Tomography (CT)	Date:		Results:
☐	Ultrasound	Date:		Results:
☐	Other, describe: _____	Date:		Results:

7B. Have clinically relevant laboratory studies been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, check all that apply:

☐	Recombinant immunoBlot assay (RIBA)	Date:		Results:
☐	Hepatitis C genotype	Date:		Results:
☐	Hepatitis C viral titers	Date:		Results:
☐	AST	Date:		Results:
☐	ALT	Date:		Results:
☐	Alkaline phosphatase	Date:		Results:
☐	Bilirubin	Date:		Results:
☐	INR (PT)	Date:		Results:
☐	Creatinine	Date:		Results:
☐	Other, describe: _____	Date:		Results:

7C. Has a liver biopsy been performed?

◯ Yes ◯ No Date of test: _____

Results:

7D. Are there any other clinically relevant diagnostic test findings and/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):

7E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION VIII - TUMORS AND NEOPLASMS

8A. 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 this section:

8B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant select all that apply):

◯ Active ◯ In remission

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

8C. 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: _____

8D. 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:

8E. 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 IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

9A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the diagnosis section above?

◯ Yes ◯ No

If yes, describe (brief summary):

9B. 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, complete appropriate dermatological questionnaire.

9C. Comments, if any:

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.

10A. 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 XI - REMARKS

11A. Remarks (if any - please identify the section to which the remark pertains when appropriate):

SECTION XII - 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.

12A. Examiner's signature:	12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	12D. Date Signed:

12E. Examiner's phone/fax numbers:	12F. National Provider Identifier (NPI) number:	12G. Medical license number and state:

12H. Examiner's address: