Department of Veterans Affairs

PANCREAS 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 conditions listed above. (Explain your findings and reasons in the Remarks section)

☐ Pancreatitis, chronic ICD Code: _____ Date of Diagnosis: _____

☐ Post pancreatectomy syndrome (total or partial pancreatectomy) ICD Code: _____ Date of Diagnosis: _____

☐ Pancreas transplant ICD Code: _____ Date of Diagnosis: _____

☐ Pancreatic neoplasm, benign ICD Code: _____ Date of Diagnosis: _____

☐ Pancreatic cancer ICD Code: _____ Date of Diagnosis: _____

☐ Other pancreas 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: _____

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

SECTION II - MEDICAL HISTORY

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

2B. Is continuous medication prescribed by a medical provider required for control of the Veteran's pancreas condition? ◯ Yes ◯ No

If yes, list only those medications for the pancreas condition:

SECTION III - PANCREAS CONDITIONS

Note: If the Veteran had a total or partial pancreatectomy, regardless of if they have pancreatitis, complete question 3A and 3B.

3A. Does the Veteran have chronic pancreatitis?

◯ Yes ◯ No ◯ No, however the Veteran had a total or partial pancreatectomy

If yes, or the Veteran had a total or partial pancreatectomy, check all that apply:

Please note, appropriate diagnostic studies must confirm that abdominal pain results from pancreatitis.

☐ Asymptomatic

☐ Episodes of abdominal or mid-back pain (indicate frequency below):

- ◯ One episode per year
- ◯ Three or more episodes per year
- ◯ Daily episodes that require three or more hospitalizations per year (if selected, also complete question 3D)

☐ Ongoing outpatient medical treatment for pain, digestive problems, or management of related complications including but not limited to cyst, pseudocyst, intestinal obstruction, or ascites

☐ One episode of abdominal or mid-back pain per year requiring hospitalization for management of complications related to abdominal pain (if checked, also complete question 3D)

☐ One episode of abdominal or mid-back pain per year requiring hospitalization for management of complications of tube enteral feeding (if checked, also complete question 3D)

☐ Pain managed by a physician

☐ Maldigestion and malabsorption requiring dietary restriction and pancreatic enzyme supplementation

☐ Diabetes Mellitus due to pancreatic insufficiency (also complete the Diabetes Mellitus questionnaire)

☐ Other symptoms, describe:

_____

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.

3B. Has the Veteran had a total or partial pancreatectomy? ◯ Yes ◯ No

If yes, was it a total or partial pancreatectomy? ◯ Total ◯ Partial Date of pancreatectomy: _____

Indicate symptoms (check all that apply):

☐ None or Asymptomatic

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

☐ 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) _____

☐ Daily episodes of watery bowel movements or diarrhea (if checked indicate frequency):

◯ Less than 3 ◯ 3 ◯ 4 ◯ 5 ◯ 6 or more

☐ Explosive bowel movements that are difficult to predict or control

☐ Recurrent abdominal pain

☐ Recurrent abdominal distention

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

☐ Requirement for medications to specifically treat complications of upper GI surgery including, but not limited to, dumping syndrome or delayed gastric emptying

☐ Requiring prescribed continuous medication (check all that apply):

☐ Symptomatology comparable to moderate inflammatory bowel disease managed on an outpatient basis with immunosuppressants or other biologic agents (if checked, list medication(s)):

_____

☐ Requiring prescribed oral dietary supplementation

☐ Other (specify): _____

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

☐ Symptomatology comparable to severe inflammatory bowel disease that is unresponsive to treatment

☐ Symptomatology comparable to severe inflammatory bowel disease that requires hospitalization at least once per year (if checked, complete question 3D)

☐ Symptomatology comparable to severe inflammatory bowel disease that results in an inability to work (if checked, discuss how condition impacts ability to work):

_____

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

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

☐ Recurrent episodes of rectal incontinence

☐ Six or more episodes per day of rectal bleeding

☐ Malabsorption - Undernutrition (see note above)

☐ Malabsorption - Anemia

☐ Short bowel syndrome that results in high-output syndrome, to include a high-output stoma

☐ Resulting in colectomy or colostomy (if checked, indicate if partial or total colectomy and select all that apply below): ◯ Partial ◯ Total

☐ Permanent colostomy ☐ More than two episodes of dehydration requiring intravenous hydration in the past 12 months

☐ Without high-output syndrome ☐ Formation of ileostomy

☐ High-output syndrome

☐ Requiring total parenteral nutrition (TPN)

◯ Intermittent ◯ Complete dependence or continuous 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 tube feedings

◯ Intermittent tube feeding for nutritional support

◯ Continuous tube feeding for nutritional support or 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: _____

☐ Vitamin or mineral deficiency as a result of pancreatic surgery

If there are Vitamin A, B, C, or D deficiencies, complete a Nutritional Deficiencies Questionnaire

If there is keratitis or keratomalacia due to a Vitamin A deficiency, complete an Eye Conditions Questionnaire (The Eye Conditions Questionnaire must be completed by an ophthalmologist or optometrist)

If there is a Vitamin E deficiency, complete a Peripheral Nerves Conditions Questionnaire

If there is a Vitamin K deficiency, complete a Hematologic and Lymphatic Conditions, Including Leukemia Questionnaire

☐ Other symptoms, describe:

3C. Has the Veteran had a pancreas transplant? ◯ Yes ◯ No

Date of transplant: _____ Date of hospital admission: _____ Facility: _____

3D. Has the Veteran had any hospitalizations for the treatment of, or complications (other than for a pancreatectomy or transplant) resulting from a pancreas condition in the past 24 months?

◯ Yes ◯ No If yes, complete the following:

Date of admission: _____ Indicate facility: _____

Provide reason for hospitalization. If there are additional hospitalizations, list using above format:

SECTION IV - TUMORS AND NEOPLASMS

4A. 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.

4B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

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

4C. 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: _____

4D. 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:

4E. 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 V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

5A. 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):

5B. 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 VI - DIAGNOSTIC TESTING

Note: Diagnosis of pancreatitis must be confirmed by appropriate laboratory and clinical studies. If testing has been performed and reflects the Veteran's current condition, no further testing is required for this examination report.

6A. Have clinically relevant imaging studies 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:
☐	Gallbladder scan (HIDA scan or cholescintigraphy)	Date:		Results:
☐	CT	Date:		Results:
☐	Other, specify:	Date:		Results:

6B. Has clinically relevant laboratory testing been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, check all that apply:

☐	Alkaline phosphatase	Date:		Results:
☐	Bilirubin	Date:		Results:
☐	WBC	Date:		Results:
☐	Amylase	Date:		Results:
☐	Lipase	Date:		Results:
☐	Other, specify:	Date:		Results:

6C. 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 in a brief summary:

6D. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION VII - 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.

7A. 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 VIII - REMARKS

8A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION IX - 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.

9A. Examiner's signature:	9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	9D. Date Signed:

9E. Examiner's phone/fax numbers:	9F. National Provider Identifier (NPI) number:	9G. Medical license number and state:

9H. Examiner's address: