Department of Veterans Affairs

PERITONEAL ADHESIONS 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, 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. Provide the diagnosis(es) that pertain to peritoneal adhesions (due to surgery, trauma, disease, or infection):

☐ 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)

Diagnosis #1		ICD code:		Date of diagnosis:	
Diagnosis #2		ICD code:		Date of diagnosis:	
Diagnosis #3		ICD code:		Date of diagnosis:	

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

SECTION II - MEDICAL HISTORY

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

2B. Provide the etiology of the Veteran's peritoneal adhesions.

☐ Surgery ☐ Trauma ☐ Inflammatory disease process, such as chronic cholecystitis or Crohn's disease

☐ Infection ☐ Other _____

2C. Indicate organ(s) affected. Check all that apply and complete the appropriate questionnaire.

☐ Stomach ☐ Gallbladder ☐ Liver ☐ Small intestines ☐ Large intestines

☐ Pancreas ☐ Other _____

SECTION III - MANIFESTATIONS OF PERITONEAL ADHESIONS

3A. Does the Veteran have peritoneal adhesions?

◯ Yes ◯ No If yes, indicate if the peritoneal adhesions are asymptomatic or symptomatic.

◯ Asymptomatic peritoneal adhesions (complete 3C).

◯ Symptomatic peritoneal adhesions (complete 3B and 3C).

3B. If peritoneal adhesions are symptomatic, check all that apply:

☐ Diarrhea

☐ Constipation

☐ Colic

☐ Vomiting

☐ Nausea

☐ Abdominal pain

☐ Medically directed dietary modification other than total parenteral nutrition (TPN)

☐ Persistent partial bowel obstruction

Is the persistent partial bowel obstruction inoperable? ◯ Yes ◯ No

Is the persistent partial bowel obstruction refractory to treatment? ◯ Yes ◯ No

Does the persistent partial bowel obstruction require (TPN) for obstructive symptoms? ◯ Yes ◯ No

☐ Clinical evidence of recurrent obstructions requiring hospitalization at least once a year (as shown and documented in the Veteran's health record(s). If checked, also complete Section IV).

3C. Does the Veteran's treatment plan include taking medication for the diagnosed condition? ◯ Yes ◯ No

If yes, list medications used.

SECTION IV - HOSPITALIZATIONS

4A. Has the Veteran had any hospitalizations for the treatment of, or complications resulting from peritoneal adhesions in the past 24 months?

◯ Yes ◯ No If yes, complete the following:

Date of admission: _____ Indicate treatment facility: _____

If there are additional hospitalizations, list using 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

6A. Are there any clinically relevant laboratory or other diagnostic studies that were reviewed in conjunction with this examination that are related to the claimed condition(s) and/or diagnosis(es)?

◯ Yes ◯ No

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

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:	