Department of Veterans Affairs

RECTUM AND ANUS 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)

☐ Hemorrhoid(s), external or internal	ICD code:	Date of diagnosis:
☐ Anorectal/perianal fistula	ICD code:	Date of diagnosis:
☐ Anorectal/perianal abscess	ICD code:	Date of diagnosis:
☐ Rectal or anal stricture	ICD code:	Date of diagnosis:
☐ Dyssynergic defecation (levator ani)	ICD code:	Date of diagnosis:
☐ Anismus (functional constipation)	ICD code:	Date of diagnosis:
☐ Impairment of sphincter control	ICD code:	Date of diagnosis:
☐ Rectal prolapse	ICD code:	Date of diagnosis:
☐ Pruritus ani (anal itching)	ICD code:	Date of diagnosis:
☐ Benign neoplasm of the anorectal/perianal region	ICD code:	Date of diagnosis:
☐ Malignant neoplasm of the anorectal/perianal region	ICD code:	Date of diagnosis:
☐ Other, specify below:		
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 rectum or anus conditions, list using above format.

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's rectum and/or anus 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 - HEMORRHOIDS

3A. Does the Veteran have hemorrhoid(s) ?

◯ Yes ◯ No If yes, indicate severity. Check all that apply:

☐ External

- ☐ Persistent bleeding
- ☐ Anemia (If checked, provide at least a hemoglobin or hematocrit value in the Diagnostic Testing Section).
- ☐ Three or more episodes per year of thrombosis

☐ None of the above

☐ Other

☐ Internal

☐ Persistent bleeding

☐ Anemia (If checked, provide at least a hemoglobin or hematocrit value in the Diagnostic Testing Section).

◯ Continuously prolapsed internal hemorrhoids with three or more episodes per year of thrombosis

◯ Prolapsed internal hemorrhoids with two or less episodes per year of thrombosis

☐ None of the above

☐ Other

SECTION IV- ANORECTAL/PERIANAL FISTULA

4A. Does the Veteran have anorectal/perianal fistula?

◯ Yes ◯ No If yes, indicate severity.

◯ One fistula

☐ With drainage ☐ With pain ☐ With abscess/abscesses

◯ Two or more simultaneous fistulas

☐ With drainage ☐ With pain ☐ With abscess/abscesses

◯ More than two constant or near-constant fistulas

☐ With drainage ☐ With pain ☐ With abscess/abscesses

4B. Is the fistula refractory to medical and surgical treatment? ◯ Yes ◯ No

SECTION V- RECTAL OR ANAL STRICTURE, INCLUDING DYSSINERGIC DEFECATION (LEVATOR ANI) OR FUNCTIONAL CONSTIPATION

Note: If the Veteran has an ostomy, also complete the Intestinal Conditions (including infectious and surgical) Disability Benefits Questionnaire.

5A. Does the Veteran have rectal or anal stricture, including dyssynergic defecation (levator ani) or functional constipation?

◯ Yes ◯ No If yes, indicate severity. Check all that apply:

☐ Luminal narrowing

◯ Reduction of the lumen by less than 50 percent ◯ Reduction of the lumen 50 percent or more

☐ Managed by dietary intervention

☐ With straining during defecation

☐ With pain during defecation

☐ Inability to open the anus with inability to expel solid feces

SECTION VI- IMPAIRMENT OF SPHINCTER CONTROL

Note: Complete or partial loss of sphincter control refers to the inability to retain or expel stool at an appropriate time and place.

6A. Does the Veteran have impairment of sphincter control?

◯ Yes ◯ No If yes, indicate severity:

◯ History of loss of sphincter control, currently asymptomatic

◯ Complete loss of sphincter control

◯ Partial loss of sphincter control

6B. Does the Veteran have incontinence to solids and/or liquids?

◯ Yes ◯ No If yes, indicate frequency:

◯ Less than once every six months, which requires wearing a pad at least once every six months

◯ At least once every six months, which requires wearing a pad at least once every six months

◯ Two or more times per month, which requires wearing a pad two or more times per month

◯ Two or more times per week, which requires wearing a pad two or more times per week

◯ Two or more times per day, which requires changing a pad two or more times per day

6C. Does the Veteran have a physician-prescribed bowel program?

◯ Yes ◯ No If yes, indicate responsiveness:

◯ Fully responsive

◯ Partially responsive

◯ Not responsive

6D. Indicate the bowel program requirements (Check all that apply)

☐ Special diet

☐ Medication If checked, are there prescribed medication(s) beyond laxative use?

◯ Yes ◯ No

☐ Digital stimulation

☐ Surgery

If checked, provide the date of surgery or anticipated date of surgery:

☐ Other, please describe:

SECTION VII- RECTAL PROLAPSE

7A. Does the Veteran have rectal prolapse?

◯ Yes ◯ No If yes, indicate severity. Check all that apply:

☐ Spontaneously reducible prolapse

☐ Manually reducible prolapse

☐ Persistent irreducible prolapse

◯ Occurs only after bowel movements, exertion, or while performing the Valsalva maneuver

◯ Occurs at times other than bowel movements, exertion, or while performing the Valsalva maneuver

◯ Unrepairable or not repairable

◯ Repairable

◯ Repaired rectal prolapse

If checked provide the date of surgery:

SECTION VIII- PRURITUS ANI (ANAL ITCHING)

8A. Does the Veteran have pruritus ani (anal itching)?

◯ Yes ◯ No If yes, indicate severity. Check all that apply:

☐ With bleeding or excoriation

☐ Without bleeding or excoriation

SECTION IX- EXAMINATION

9A. Provide results of examination of rectal/anal area. Check all that apply.

☐ No exam performed for this condition. Provide reason:

☐ Normal; no external hemorrhoids, anal fissures or other abnormalities

☐ Abnormal, describe: Abnormal, describe

SECTION X - TUMORS AND NEOPLASMS

10A. 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.

10B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

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

10C. 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: _____

10D. 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:

10E. 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 XI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

11A. 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):

11B. 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 XII - DIAGNOSTIC TESTING

Note: If imaging studies, diagnostic procedures or laboratory testing have been performed and reflect the Veteran's current condition, no further testing is required for this examination report.

12A. Have clinically relevant laboratory testing been performed or reviewed in conjunction with this examination?

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

☐	Hemoglobin:	Date of test:		Results:
☐	Hematocrit:	Date of test:		Results:
☐	White blood cell count:	Date of test:		Results:
☐	Platelets:	Date of test:		Results:
☐	Other, specify:	Date of test:		Results:

12B. Have clinically relevant imaging studies or diagnostic procedures been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

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

12C. 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):

12D. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION XIII - 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.

13A. 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 XIV - REMARKS

14A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XV - 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.

15A. Examiner's signature:	15B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):	
15C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):		15D. Date Signed:
15E. Examiner's phone/fax numbers:	15F. National Provider Identifier (NPI) number:	15G. Medical license number and state:
15H. Examiner's address:		