Department of Veterans Affairs

HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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 questionnaires completed by providers. It is intended that this questionnaire will be completed by the Veteran's provider.

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

☐ Veteran/Claimant

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ 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

1A. CHECK THE CLAIMED HEMATOLOGICAL AND/OR LYMPHATIC CONDITION(S) THAT PERTAIN TO THIS DBQ:

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 comments section. Date of diagnosis can be the date of evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

☐ Agranulocytosis, acquired — ICD code: _____ Date of diagnosis: _____

☐ Leukemia

- ☐ Chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia) — ICD code: _____ Date of diagnosis: _____
- ☐ Chronic lymphocytic leukemia (CLL) — ICD code: _____ Date of diagnosis: _____

☐ Hairy cell or other B-cell leukemia ICD code: _____ Date of diagnosis: _____

☐ Other _____ ICD code: _____ Date of diagnosis: _____

☐ Hodgkin's lymphoma ICD code: _____ Date of diagnosis: _____

☐ Active disease ☐ Treatment phase

☐ Non-Hodgkin's lymphoma ICD code: _____ Date of diagnosis: _____

☐ Active disease ☐ Treatment phase ☐ Indolent and non-contiguous phase of low grade NHL

☐ Multiple myeloma ICD code: _____ Date of diagnosis: _____

☐ Monoclonal gammopathy of undetermined significance (MGUS) ICD code: _____ Date of diagnosis: _____

☐ Myelodysplastic syndrome ICD code: _____ Date of diagnosis: _____

☐ Solitary plasmacytoma ICD code: _____ Date of diagnosis: _____

☐ Anemia

☐ Aplastic anemia ICD code: _____ Date of diagnosis: _____

☐ Iron deficiency anemia ICD code: _____ Date of diagnosis: _____

☐ Folic acid deficiency ICD code: _____ Date of diagnosis: _____

☐ Pernicious anemia or other Vitamin B12 deficiency anemia ICD code: _____ Date of diagnosis: _____

☐ Acquired hemolytic anemia ICD code: _____ Date of diagnosis: _____

☐ Other _____ ICD code: _____ Date of diagnosis: _____

☐ AL amyloidosis (primary amyloidosis) ICD code: _____ Date of diagnosis: _____

☐ Immune thrombocytopenia ICD code: _____ Date of diagnosis: _____

☐ Polycythemia vera ICD code: _____ Date of diagnosis: _____

☐ Sickle cell anemia ICD code: _____ Date of diagnosis: _____

☐ Splenectomy ICD code: _____ Date of diagnosis: _____

Are there complications such as systemic infections with encapsulated bacteria? ◯ Yes ◯ No

If Yes, complete SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS.

☐ Injury to Spleen ICD code: _____ Date of diagnosis: _____

If checked, complete SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS.

☐ Adenitis, tuberculous (Also complete the Infectious Diseases (Other Than HIV-Related Illness, Chronic Fatigue Syndrome, or Tuberculosis) Disability Benefits Questionnaire). ICD code: _____ Date of diagnosis: _____

◯ Active ◯ Inactive

☐ Essential thrombocythemia or primary myelofibrosis ICD code: _____ Date of diagnosis: _____

☐ Other, specify

Other diagnosis #1: _____ ICD code: _____ Date of diagnosis: _____

Other diagnosis #2: ICD code: Date of diagnosis:

Other diagnosis #3: ICD code: Date of diagnosis:

1B. IF THERE ARE ADDITIONAL OR PRIOR DIAGNOSES THAT PERTAIN TO HEMATOLOGIC OR LYMPHATIC CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including cause (if known), onset and course) OF THE VETERAN'S CURRENT HEMATOLOGIC OR LYMPHATIC CONDITION(S) (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF A HEMATOLOGIC OR LYMPHATIC CONDITION, INCLUDING ANEMIA OR THROMBOCYTOPENIA CAUSED BY TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC CONDITION?

◯ Yes ◯ No

IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR CONTROL OF THE VETERAN'S HEMATOLOGIC OR LYMPHATIC CONDITION, INCLUDING ANEMIA OR THROMBOCYTOPENIA CAUSED BY TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC CONDITION. PROVIDE THE NAME OF THE MEDICATION AND THE CONDITION THE MEDICATION IS USED TO TREAT:

2C. INDICATE THE STATUS OF THE PRIMARY HEMATOLOGIC OR LYMPHATIC CONDITION:

☐ ACTIVE ☐ REMISSION ☐ NOT APPLICABLE

SECTION III - TREATMENT

3A. HAS THE VETERAN COMPLETED ANY TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING ANY TREATMENT FOR ANY HEMATOLOGIC OR LYMPHATIC CONDITION, INCLUDING LEUKEMIA?

◯ Yes ◯ No; watchful waiting

IF YES, INDICATE TYPE OF TREATMENT THE VETERAN IS CURRENTLY UNDERGOING OR HAS COMPLETED (Check all that apply):

☐ Treatment completed; currently in watchful waiting status

☐ Transplant (specify type)

☐ Peripheral blood stem cell transplant ☐ Bone marrow stem cell transplant

☐ Other (specify)

If checked, provide:

Date of hospital admission and location: _____

Date of hospital discharge after transplant: _____

☐ 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: _____

SECTION IV - ANEMIA AND THROMBOCYTOPENIA

4A. DOES THE VETERAN HAVE ANEMIA OR THROMBOCYTOPENIA, INCLUDING THAT CAUSED BY TREATMENT FOR A HEMATOLOGIC OR LYMPHATIC CONDITION?

◯ Yes ◯ No IF YES, COMPLETE THE FOLLOWING:

4B. DOES THE VETERAN HAVE ANEMIA (other than Sickle Cell Anemia) OR THROMBOCYTOPENIA?

◯ Yes ◯ No IF YES, PLEASE CHECK TYPE:

☐ Aplastic anemia (complete 4C)

☐ Iron deficiency anemia (complete 4D)

☐ Folic acid deficiency (complete 4E)

☐ Pernicious anemia or other Vitamin B12 deficiency anemia (complete 4F)

☐ Acquired hemolytic anemia (complete 4G)

☐ Immune thrombocytopenia (complete 4H)

☐ Other, specify _____

IS THE ANEMIA CAUSED BY TREATMENT FOR ANOTHER HEMATOLOGIC OR LYMPHATIC CONDITION?

◯ Yes ◯ No IF YES, PROVIDE THE NAME OF THE OTHER HEMATOLOGIC OR LYMPHATIC CONDITION CAUSING THE SECONDARY ANEMIA:

4C. APLASTIC ANEMIA:

- [ ] Requiring peripheral blood stem cell transplant
- [ ] Requiring bone marrow stem cell transplant
- [ ] Requiring transfusion of platelets, on average, at least:
    - [ ] once every six weeks per 12-month period
    - [ ] once every three months per 12-month period
    - [ ] once per 12-month period
- [ ] Requiring transfusion of red cells, on average, at least:
    - [ ] once every six weeks per 12-month period
    - [ ] once every three months per 12-month period
    - [ ] once per 12-month period
- [ ] Infections recurring, on average, at least:
    - [ ] once every six weeks per 12-month period
    - [ ] once every three months per 12-month period
    - [ ] once per 12-month period
- [ ] Using continuous therapy with immunosuppressive agent
- [ ] Using continuous therapy with newer platelet stimulating factors

NOTE: The term "newer platelet stimulating factors" includes medication, factors, or other agents approved by the United States Food and Drug Administration.

4D. IRON DEFICIENCY ANEMIA

- [ ] Requiring intravenous iron infusions 4 or more times per 12-month period
- [ ] Requiring intravenous iron infusions at least 1 time but less than 4 times per 12-month period
- [ ] Requiring continuous treatment with oral supplementation
- [ ] Requiring treatment only by dietary modification
- [ ] Asymptomatic

4E. FOLIC ACID DEFICIENCY

- [ ] Requiring continuous treatment with high-dose oral supplementation
- [ ] Requiring treatment only by dietary modification
- [ ] Asymptomatic

4F. PERNICIOUS ANEMIA OR OTHER VITAMIN B12 DEFICIENCY ANEMIA

☐ For initial diagnosis requiring transfusion due to severe anemia

If checked, provide the date of initial diagnosis requiring transfusion _____ and

the date of hospital discharge or cessation of parenteral B12 therapy _____

☐ Signs or symptoms related to central nervous system impairment, such as encephalopathy, myelopathy, or severe peripheral neuropathy, requiring parenteral B12 therapy

☐ Requiring continuous treatment with Vitamin B12 injections

☐ Requiring continuous treatment with Vitamin B12 sublingual tablets

☐ Requiring continuous treatment with high-dose oral tablets

☐ Requiring continuous treatment with Vitamin B12 nasal spray or gel

NOTE: If there are any residual effects of pernicious anemia, such as neurologic involvement causing peripheral neuropathy, myelopathy, dementia, or related gastrointestinal residuals, ALSO complete appropriate Questionnaire for each condition.

4G. ACQUIRED HEMOLYTIC ANEMIA

☐ Required a bone marrow transplant

☐ Requiring continuous intravenous or immunosuppressive therapy (e.g., prednisone, Cytoxan, azathioprine, or rituximab)

☐ Requiring immunosuppressive medication 4 or more times per 12-month period

☐ Requiring 2-3 courses of immunosuppressive therapy per 12-month period

☐ Requiring one course of immunosuppressive therapy per 12-month period

☐ Asymptomatic

4H. IMMUNE THROMBOCYTOPENIA

☐ Requiring chemotherapy for chronic refractory thrombocytopenia

☐ Requiring immunosuppressive therapy

☐ Platelet count 30,000 or below despite treatment

☐ Platelet count higher than 30,000 but not higher than 50,000 with history of hospitalization because of severe bleeding requiring intravenous immune globulin, high dose parenteral corticosteroids, and platelet transfusions

☐ Platelet count higher than 30,000 but not higher than 50,000 with mild mucous membrane bleeding which requires oral corticosteroid therapy or intravenous immune globulin

☐ Platelet count higher than 30,000 but not higher than 50,000 with immune thrombocytopenia which requires oral corticosteroid therapy or intravenous immune globulin

☐ Platelet count higher than 30,000 but not higher than 50,000, not requiring treatment

☐ Platelet count above 50,000 and asymptomatic

☐ In remission

SECTION V - LEUKEMIA, MULTIPLE MYELOMA, MONOCLONAL GAMMOPATHY OF UNDETERMINED SIGNIFICANCE (MGUS), AGRANULOCYTOSIS, ACQUIRED, ESSENTIAL THROMBOCYTHEMIA, PRIMARY MYELOFIBROSIS, AND MYELODYSPLASTIC SYNDROMES

5A. DOES THE VETERAN HAVE LEUKEMIA, MULTIPLE MYELOMA, MONOCLONAL GAMMOPATHY OF UNDETERMINED SIGNIFICANCE (MGUS), AGRANULOCYTOSIS, ACQUIRED, ESSENTIAL THROMBOCYTHEMIA, PRIMARY MYELOFIBROSIS, OR MYELODYSPLASTIC SYNDROMES?

◯ Yes ◯ No IF YES, PLEASE CHECK TYPE:

☐ Chronic lymphocytic leukemia (complete 5B)

☐ Monoclonal B-cell lymphocytosis (MBL) (complete 5B)

- [ ] Hairy cell or other B-cell leukemia (complete 5B)
- [ ] Chronic myelogenous leukemia (complete 5B
- [ ] Chronic myeloid leukemia (complete 5B)
- [ ] Chronic granulocytic leukemia (complete 5B)
- [ ] Multiple myeloma (complete 5C)
- [ ] Monoclonal gammopathy of undetermined significance (MGUS) (complete 5C)
- [ ] Agranulocytosis, acquired (complete 5D)
- [ ] Essential thrombocythemia or primary myelofibrosis (complete 5E)
- [ ] Myelodysplastic syndromes (complete 5F)
- [ ] Other, specify _____

5B. WHAT IS THE STATUS OF LEUKEMIA?

○ ACTIVE ○ REMISSION

- [ ] Asymptomatic, Rai Stage 0
- [ ] Requiring peripheral blood stem cell transplant
- [ ] Requiring bone marrow stem cell transplant
- [ ] Requiring continuous myelosuppressive therapy
- [ ] Requiring continuous immunosuppressive therapy treatment
- [ ] Requiring intermittent myelosuppressive therapy, or molecularly targeted therapy with tyrosine kinase inhibitors, or interferon treatment when not in apparent remission
- [ ] In apparent remission on continuous molecularly targeted therapy with tyrosine kinase inhibitors

5C. WHAT IS THE STATUS OF MULTIPLE MYELOMA?

- [ ] Asymptomatic
- [ ] Monoclonal gammopathy of undetermined significance (MGUS)
- [ ] Smoldering multiple myeloma (SMM)
- [ ] Symptomatic (if checked, provide date of the diagnosis of symptomatic multiple myeloma) _____

NOTE: Current validated biomarkers of symptomatic multiple myeloma, asymptomatic, smoldering or monoclonal gammopathy of undetermined significance (MGUS) are acceptable for the diagnosis of multiple myeloma as defined by the American Society of Hematology (ASH) and International Myeloma Working Group (IMWG).

5D. WHAT IS THE STATUS OF AGRANULOCYTOSIS, ACQUIRED?

- [ ] Requiring bone marrow transplant
- [ ] Requiring intermittent myeloid growth factors (granulocyte colony-stimulating factor (G-CSF) or granulocyte-macrophage colony-stimulating factor (GM-CSF))
- [ ] Requiring continuous immunosuppressive therapy such as cyclosporine to maintain absolute neutrophil count (ANC) greater than 500/microliter (l) but less than 1000/l
- [ ] Requiring intermittent myeloid growth factors to maintain ANC greater than 1000/l
- [ ] Requiring intermittent use of a myeloid growth factor to maintain ANC greater than or equal to 1500/l

- [ ] Infections recurring, on average, at least once every six weeks per 12-month period
- [ ] Infections recurring, on average, at least once every three months per 12-month period
- [ ] Infections recurring, on average, at least once per 12-month period but less than once every three months per 12-month period
- [ ] Requiring continuous medication (e.g., antibiotics) for control

5E. WHAT IS THE STATUS OF ESSENTIAL THROMBOCYTHEMIA AND PRIMARY MYELOFIBROSIS?

- [ ] Requiring continuous myelosuppressive therapy
- [ ] Requiring intermittent myelosuppressive therapy
- [ ] Requiring peripheral blood stem cell transplant
- [ ] Requiring bone marrow stem cell transplant
- [ ] Requiring chemotherapy
- [ ] Requiring interferon treatment
- [ ] Requiring interferon treatment to maintain platelet count < 500 x 10 9/L
- [ ] Requiring interferon treatment to maintain platelet count of 200,000-400,000
- [ ] Requiring interferon treatment to maintain white blood cell (WBC) count of 4,000-10,000
- [ ] Asymptomatic

5F. WHAT IS THE STATUS OF MYELODYSPLASTIC SYNDROMES?

- [ ] Requiring peripheral blood stem cell transplant
- [ ] Requiring bone marrow stem cell transplant
- [ ] Requiring chemotherapy
- [ ] Requiring 4 or more blood or platelet transfusions per 12-month period
- [ ] Requiring 1 to 3 blood or platelet transfusions per 12-month period
- [ ] Infections requiring hospitalization 3 or more times per 12-month period
- [ ] Infections requiring hospitalization 1 to 2 times per 12-month period
- [ ] Requiring biologic therapy on an ongoing basis
- [ ] Requiring erythropoiesis stimulating agent (ESA) for 12 weeks or less per 12-month period

SECTION VI - POLYCYTHEMIA VERA

6A. DOES THE VETERAN HAVE POLYCYTHEMIA VERA?

◯ Yes ◯ No IF YES, CHECK ALL THAT APPLY:

- [ ] Requiring peripheral blood or bone marrow stem-cell transplant for the purpose of ameliorating the symptom burden
- [ ] Requiring chemotherapy (including myelosuppressants) for the purpose of ameliorating the symptom burden
- [ ] Requiring phlebotomy 6 or more times per 12-month period or molecularly targeted therapy for the purpose of controlling RBC count
- [ ] Requiring phlebotomy 4-5 times per 12-month period to maintain platelets < 200,000 or white blood cells (WBC) < 12,000

☐ Requiring phlebotomy 3 or fewer times per 12-month period to maintain all blood values at reference range levels

☐ Requiring continuous biologic therapy or myelosuppresive agents, to include interferon, to maintain platelets < 200,000 or white blood cells (WBC) < 12,000

☐ Requiring biologic therapy or interferon on an intermittent basis as needed to maintain all blood values at reference range levels

☐ Other, describe: _____

NOTE: If there are complications due to polycythemia vera such as hypertension, gout, stroke or thrombotic disease, ALSO complete appropriate Questionnaire for each condition.

SECTION VII - SICKLE CELL ANEMIA

7A. DOES THE VETERAN HAVE SICKLE CELL ANEMIA?

◯ Yes ◯ No IF YES, CHECK ALL THAT APPLY:

☐ Symptoms preclude even light manual labor

☐ Symptoms preclude other than light manual labor

☐ With anemia, thrombosis, and infarction

☐ With at least 4 or more painful episodes per 12-month period, occurring in skin, joints, bones, or any major organs caused by hemolysis and sickling of red blood cells

☐ With 3 painful episodes per 12-month period

☐ With 1 or 2 painful episodes per 12-month period

☐ With identifiable organ impairment

☐ In remission

☐ Asymptomatic

☐ Other, describe: _____

SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

8A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

◯ Yes ◯ No

If yes, describe (brief summary):
Also if indicated, complete the appropriate questionnaire for each condition

8B. 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 APPROPRIATE DERMATOLOGICAL DBQ

SECTION IX - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects Veteran's current condition, no further testing is required. When appropriate, provide most recent complete blood count.

9A. HAS LABORATORY TESTING BEEN PERFORMED?

◯ Yes ◯ No IF YES, PROVIDE RESULTS:

Hemoglobin (gm/100ml): _____ Date: _____

Hematocrit:		Date:	
Red blood cell (RBC) count:		Date:	
White blood cell (WBC) count:		Date:	
White blood cell differential count:		Date:	
Platelet count:		Date:	

9B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

◯ Yes ◯ No IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (brief summary):

SECTION X - FUNCTIONAL IMPACT

10. DOES THE VETERAN'S HEMATOLOGIC OR LYMPHATIC CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

◯ Yes ◯ No

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S HEMATOLOGIC AND/OR LYMPHATIC CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION XI - REMARKS

11. REMARKS (If any):

SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

12A. Examiner's signature:	12. 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:		