Department of Veterans Affairs

NON-DEGENERATIVE ARTHRITIS (INCLUDING INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE AND INFECTIOUS) AND DECOMPRESSION ILLNESS 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.

Dominant Hand

Dominant hand: ◯ Right ◯ Left ◯ Ambidextrous

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 at the end of this questionnaire.)

☐ Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process (conditions include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, and spondyloarthropathies) - ICD Code: _____ Date of Diagnosis: _____

Please specify diagnosis(es): _____

☐ Arthritis, gonorrheal ICD Code: _____ Date of Diagnosis: _____

☐ Arthritis, pneumococcic ICD Code: _____ Date of Diagnosis: _____

☐ Arthritis, typhoid ICD Code: _____ Date of Diagnosis: _____

☐ Arthritis, syphilitic ICD Code: _____ Date of Diagnosis: _____

☐ Arthritis, streptococcic ICD Code: _____ Date of Diagnosis: _____

☐ Decompression illness (previously dysbaric osteocrenosis/caisson disease) ICD Code: _____ Date of Diagnosis: _____

☐ Other specified forms of arthropathy (excluding gout) (conditions include, but are not limited to, Charcot neuropathic, hypertrophic, crystalline, and other autoimmune arthropathies) - ICD Code: _____ Date of Diagnosis: _____

Please specify diagnosis: _____

☐ Other (specify): If checked, provide only diagnoses that pertain to inflammatory, autoimmune, crystalline or infectious arthritis.

Other diagnosis #1 _____ ICD Code: _____ Date of Diagnosis: _____

Other diagnosis #2 _____ ICD Code: _____ Date of Diagnosis: _____

Other diagnosis #3 _____ ICD Code: _____ Date of Diagnosis: _____

If there are additional diagnoses that pertain to non-degenerative arthritis conditions, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's inflammatory, autoimmune, crystalline or infectious arthritis, or decompression illness (brief summary):

2B. Does the Veteran require continuous use of medication for the arthritis condition? ◯ Yes ◯ No

If yes, list only those medications used for this arthritis condition:

2C. Has the Veteran lost weight due to the arthritis condition? ◯ Yes ◯ No

If yes, provide baseline weight (average weight for 2-year period preceding onset of disease): _____ and current weight: _____

If yes, does the Veteran's weight loss (attributable to the arthritis condition) cause impairment of health? ◯ Yes ◯ No

If yes, describe the impairment:

2D. Does the Veteran have anemia due to the arthritis condition? ◯ Yes ◯ No

If yes, does the Veteran's anemia (which is attributable to the arthritis condition) cause impairment of health? ◯ Yes ◯ No

If yes, describe the impairment, and also provide Complete Blood Count (CBC) under Section IX - Diagnostic Testing:

SECTION III - JOINT INVOLVEMENT

Note: If joint involvement (e.g., pain, limitation of motion, joint deformity) is present, complete the appropriate questionnaire for each identified joint. Also complete the appropriate questionnaire for each affected body system, if indicated.

3A. Does the Veteran have any joint involvement (e.g., pain, limitation of motion, joint deformity) attributable to the arthritis condition? ◯ Yes ◯ No

If yes, indicate affected joints. Check all that apply:

☐ Cervical spine ☐ Thoracolumbar spine ☐ Sacroiliac joints

Right:	☐ Shoulder	☐ Elbow	☐ Wrist	☐ Hand/fingers
	☐ Hip	☐ Knee	☐ Ankle	☐ Foot/toes
Left:	☐ Shoulder	☐ Elbow	☐ Wrist	☐ Hand/fingers
	☐ Hip	☐ Knee	☐ Ankle	☐ Foot/toes

For all checked joints, describe involvement (brief summary):

SECTION IV - SYSTEMIC INVOLVEMENT OTHER THAN JOINTS

4A. Does the Veteran have any involvement of any body systems, other than joints, attributable to the arthritis condition? ◯ Yes ◯ No

If yes, indicate systems involved. Check all that apply.

☐ Opthalmological ☐ Skin and mucous membranes ☐ Hematological ☐ Pulmonary ☐ Cardiac

☐ Neurological ☐ Renal ☐ Gastrointestinal ☐ Vascular ☐ Other

For all checked systems, describe involvement (brief summary). Also complete the appropriate questionnaire for each affected body system, if indicated.

4B. Comments (if any):

SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS

5A. Due to the arthritis condition, does the Veteran have exacerbations which are not incapacitating? ◯ Yes ◯ No

If yes, indicate frequency of non-incapacitating exacerbations per year (on average):

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more

Date of most recent non-incapacitating exacerbation: _____

Duration of most recent non-incapacitating exacerbation: _____

Describe non-incapacitating exacerbation: _____

5B. Due to the arthritis condition, does the Veteran have exacerbations which are incapacitating? ◯ Yes ◯ No

If yes, indicate frequency of incapacitating exacerbations per year (on average):

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more

Indicate the total duration of incapacitation over the past 12 months:

◯ < 1 week

◯ 1 week to < 2 weeks

◯ 2 weeks to < 4 weeks

◯ 4 weeks to < 6 weeks

◯ 6 weeks or more

Date of most recent incapacitating exacerbation: _____

Duration of most recent incapacitating exacerbation: _____

Describe incapacitating exacerbation: _____

5C. Is the Veteran's arthritis manifested by constitutional manifestations associated with active joint involvement which are totally incapacitating?

◯ Yes ◯ No

5D. Is the Veteran's arthritis manifested by weight loss and anemia productive of severe impairment of health?

◯ Yes ◯ No

5E. Is the Veteran's arthritis manifested by severely incapacitating exacerbations occurring four or more times a year, or a lesser number over prolonged periods?

◯ Yes ◯ No

5F. Is the Veteran's arthritis manifested by symptom combinations productive of definite impairment of health, objectively supported by examination findings?

◯ Yes ◯ No

SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

6A. 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):

6B. 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 VII - ASSISTIVE DEVICES

7A. Does the Veteran use any assistive devices as a normal mode of locomotion, although occassional locomotion by other methods may be possible?

◯ Yes ◯ No

If yes, identify the assistive devices used. Check all that apply and indicate frequency:

☐ Wheelchair	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Brace(s)	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Crutch(es)	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Cane(s)	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Walker	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant
☐ Other: _____	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant

7B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition:

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

Note: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prothesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

8A. Due to the Veteran's arthritis condition, is there functional impairment of an extremity such that no effective function remains, other than that which would be equally well-served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance, propulsion, etc.)

◯ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran

◯ No

If yes, indicate extremities for which this applies: ☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

8B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

SECTION IX - DIAGNOSTIC TESTING

Note: Testing listed below is not indicated for every condition.

9A. Have clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination? ◯ Yes ◯ No

Was arthritis documented? ◯ Yes ◯ No

If yes, indicate type of study:

☐ X-ray Area(s) imaged: _____ Date: _____

Results: _____

☐ Other, specify: _____ Area(s) imaged: _____ Date: _____

Results _____

9B. Has clinically relevant laboratory testing been performed or reviewed in conjunction with this examination? ◯ Yes ◯ No If yes, check all that apply:

☐ Erythrocyte sedimentation rate (ESR) Date of test: _____ Results: _____

☐ C-reaction protein Date of test: _____ Results: _____

☐ Rheumatoid factor (RF) Date of test: _____ Results: _____

☐ Anti-DNA antibodies Date of test: _____ Results: _____

☐ Antinuclear antibodies (ANA) Date of test: _____ Results: _____

☐ Anti-cyclic citrullinated peptide (ANTI - CCP) antibodies Date of test: _____ Results: _____

☐ CBC Date of test: _____ Results: _____

Hemoglobin: _____ Hematocrit: _____ White Blood cell count _____ Platelets _____

☐ Uric acid test Date of test: _____ Results: _____

☐ Other, specify: _____ Date of test: _____ Results: _____

If any test results in this section are other than normal, include normal reference ranges for your facility.

9C. Has the Veteran had a joint aspiration or synovial fluid analysis? ◯ Yes ◯ No

If yes, indicate joint aspirated, date and results:

9D. Has the Veteran had a biopsy? ◯ Yes ◯ No

If yes, indicate area biopsied, date and results:

9E. 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):

9F. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed condition(s):

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:	