



INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS, CHRONIC FATIGUE SYNDROME, OR TUBERCULOSIS) 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:

Form with checkboxes for 'Veteran/Claimant', 'Third party (please list name(s) of organization(s) or individual(s))', and 'Other: please describe' with corresponding text boxes.

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? [Text box]

EVIDENCE REVIEW

Evidence reviewed:

Radio buttons for 'No records were reviewed' and 'Records reviewed'

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

[Large empty text box for evidence review details]

SECTION I - DIAGNOSIS

1A. Does the Veteran now have or has he or she ever been diagnosed with an infectious disease?

Radio buttons for 'Yes' and 'No' with instruction 'If "Yes," complete Item 1B'

1B. Select the Veteran's condition (Check all that apply):

<input type="checkbox"/> Bartonellosis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Brucellosis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Campylobacter jejuni infection	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Coxiella burnetii infection (Q fever)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Hemorrhagic fevers, including dengue, yellow fever, and others	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Hyperinfection syndrome or disseminated strongyloidiasis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Leprosy	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Lyme disease	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Lymphatic filariasis, to include elephantiasis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Malaria	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Melioidosis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Miliary tuberculosis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Nontuberculosis mycobacterial infection (NTM)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Nontyphoid salmonella infections	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Parasitic disease otherwise not specified	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Plague	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Relapsing fever	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Rheumatic fever	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Rickettsial, ehrlichia, and anaplasma infections	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Schistosomiasis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Shigella infections	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Syphilis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Vibriosis (cholera)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Visceral leishmaniasis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> West Nile virus infection	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Other (specify):	ICD code: _____	Date of diagnosis: _____
Other diagnosis #1:		
_____	ICD code: _____	Date of diagnosis: _____
Other diagnosis #2:		
_____	ICD code: _____	Date of diagnosis: _____

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

**SECTION II - MEDICAL HISTORY**

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

**SECTION III - STATUS, SYMPTOMS, AND RESIDUALS**

3A. Complete the following section(s) for each of the Veteran's infectious disease condition(s):

Disease #1:

\_\_\_\_\_

A. Status of disease:      Active                       Inactive

Date of cessation of treatment for active disease: \_\_\_\_\_

If "Inactive," date condition became inactive: \_\_\_\_\_

B. Does the Veteran have symptoms attributable to disease #1?

Yes      No

If "Yes," describe: \_\_\_\_\_

C. Does the Veteran have residuals attributable to disease #1?

Yes      No

If "Yes," describe: \_\_\_\_\_

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

Disease #2:

\_\_\_\_\_

A. Status of disease:      Active                       Inactive

Date of cessation of treatment for active disease: \_\_\_\_\_

If "Inactive," date condition became inactive: \_\_\_\_\_

B. Does the Veteran have symptoms attributable to disease #2?

Yes      No

If "Yes," describe: \_\_\_\_\_

C. Does the Veteran have residuals attributable to disease #2?

Yes      No

If "Yes," describe: \_\_\_\_\_

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

Disease #3: \_\_\_\_\_

A. Status of disease:      Active                    Inactive

Date of cessation of treatment for active disease: \_\_\_\_\_

If "Inactive," date condition became inactive: \_\_\_\_\_

B. Does the Veteran have symptoms attributable to disease #3?

Yes      No

If "Yes," describe: \_\_\_\_\_

C. Does the Veteran have residuals attributable to disease #3?

Yes      No

If "Yes," describe: \_\_\_\_\_

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

3B. If the Veteran has any additional infectious disease conditions, list and describe by using the above format:

**SECTION IV - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS**

4A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any of the conditions listed in the Diagnosis section?

Yes      No     If "Yes," describe (brief summary):

4B. 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:

4C. Comments, if any:

**SECTION V - DIAGNOSTIC TESTING**

Note: VA requires diagnostic confirmation for both the initial diagnosis and any relapse or recurrence. Certain infectious diseases require specific testing methods to confirm recurrence of active infection. If testing has been performed and reflects Veteran's current condition, repeat testing is not required. (For VA purposes, relapse is defined as a full return of a disease or the signs and symptoms of a disease after a period of improvement and recurrence refers to another separate disease episode after a full recovery has been attained).

5A. For visceral leishmaniasis, miliary tuberculosis or nontuberculosis mycobacterium infection, please state if the recurrence of active infection is confirmed by:

- Culture
- Histopathology
- Other diagnostic laboratory testing

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

5B. For malaria, please state if the initial diagnosis or relapse is confirmed by:

- Identification of the malarial parasites in blood smears
- Identification of the malarial parasites in other specific diagnostic laboratory tests, such as antigen detection, immunologic (immunochromatographic) tests, or molecular testing such as polymerase chain reaction tests

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

5C. For brucellosis, please state if the initial diagnosis or recurrence of active infection is confirmed by:

- Culture
- Serologic testing

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

5D. For melioidosis, please state if the initial diagnosis and any relapse or chronic activity of infection is confirmed by:

- Culture
- Other specific diagnostic laboratory tests

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

5E. For initial diagnosis, relapse, or recurrence of all other infectious diseases, please state the way in which active infection is confirmed:

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

**SECTION VI - FUNCTIONAL IMPACT**

6A. Does the Veteran's infectious disease condition(s) impact his or her ability to work?

Yes     No

If "Yes," describe the impact of each of the Veteran's infectious disease condition(s), providing one or more examples:

**SECTION VII - REMARKS**

7A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

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**SECTION VIII - 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.

8A. Examiner's signature: _____		8B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C): _____	
8C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice): _____		8D. Date Signed: _____	
8E. Examiner's phone/fax numbers: _____	8F. National Provider Identifier (NPI) number: _____	8G. Medical license number and state: _____	
8H. Examiner's address: _____ _____			