Department of Veterans Affairs

LOSS OF SENSE OF SMELL AND/OR TASTE 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. Does the Veteran now have or has he or she ever been diagnosed with loss of sense of smell or taste? (This is the condition the Veteran is claiming or for which an exam has been requested.)

◯ Yes ◯ No

If yes, select the Veteran's condition (check all that apply):

☐ Anosmia (inability to detect any odor) ICD Code: Date of diagnosis:

☐ Hyposmia (reduced ability to detect any odors) ICD Code: Date of diagnosis:

☐ Ageusia (complete lack of taste) ICD Code: Date of diagnosis:

☐ Hypogeusia (decrease in sense of taste) ICD Code: _____ Date of diagnosis: _____

☐ Other (specify):

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

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

1B. If there are additional diagnoses that pertain to complete loss of sense of smell or taste, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's loss of sense of smell or taste (brief summary):

SECTION III - SYMPTOMS

3A. Does the Veteran currently have loss of sense of smell?

◯ Yes ◯ No

If yes, indicate severity:

◯ Partial

◯ Complete

If yes, is there a known anatomical or pathological basis for this condition?

◯ Yes ◯ No

If yes, describe:

3B. Does the Veteran currently have loss of sense of taste?

◯ Yes ◯ No

If yes, indicate severity:

◯ Partial

◯ Complete

If yes, is there a known anatomical or pathological basis for this condition?

◯ Yes ◯ No

If yes, describe:

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

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

◯ 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 the appropriate dermatological questionnaire.

4C. Comments, if any:

SECTION V - DIAGNOSTIC TESTING

Note: If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for a loss of smell and taste examination.

5A. Have clinically relevant diagnostic imaging or laboratory studies been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, check all that apply:

☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____

☐ Computed tomography (CT) Date: _____ Results: _____

☐ Other: _____ Date: _____ Results: _____

5B. Has qualitative smell and/or taste testing been performed in conjunction with this examination?

◯ Yes ◯ No

If yes, complete the following:

Type of test: _____ Date: _____ Results: _____

Type of test: _____ Date: _____ Results: _____

5C. 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 in a brief summary:

SECTION VI - FUNCTIONAL IMPACT

6A. 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 VII - REMARKS

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

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: