Department of Veterans Affairs

NARCOLEPSY
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:

1B. Does the Veteran have or has he or she ever been diagnosed with narcolepsy? (This is the condition the Veteran is claiming or for which an exam has been requested)

◯ Yes ◯ No

1C. If yes, check the appropriate diagnoses (check all that apply):

☐ Narcolepsy ICD Code: _____ Date of Diagnosis: _____

☐ Other (specify):

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

1D. If there are additional diagnoses that pertain to narcolepsy, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's narcolepsy. Brief summary:

2B. Is continuous medication required for control of narcolepsy?

◯ Yes ◯ No

If yes, list only those medications used for the Veteran's narcolepsy:

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

Does the Veteran have a confirmed diagnosis of narcolepsy?

◯ Yes ◯ No If yes, complete 3A and 3B:

3A. If yes, does the Veteran report any of the following findings, signs or symptoms?

◯ Yes ◯ No

(If "Yes," check all that apply):

☐ Excessive daytime sleepiness

☐ Sleep attacks (strong urge to sleep followed by short nap)

☐ Cataplexy (sudden loss of muscle tone while awake, resulting in brief inability to move)

☐ Sleep paralysis (inability to move on first awakening)

☐ Sleep onset/sleep offset hallucinations

☐ Other

(For all checked conditions, describe):

3B. Indicate frequency of cataplectic (narcoleptic) episodes (check all that apply):

Number of cataplectic (narcoleptic) episodes over past 6 months

◯ 0-1 ◯ 2 or more

(If 2 or more over the past 6 months, indicate the "average frequency" of narcoleptic episodes):

◯ 0-4 per week ◯ 5-8 per week ◯ 9-10 per week ◯ More than 10 per week

(If the Veteran has cataplectic (narcoleptic) episodes, describe):

3C. Has the Veteran ever had major seizures (characterized by the generalized tonic-clonic convulsion with unconsciousness)?

◯ Yes ◯ No

Number of major seizures:

◯ None in past 2 years ◯ At least 1 in past 2 years ◯ At least 2 in past years

Average frequency of major seizures:

◯ None in past 6 months ◯ At least 1 in 3 months over past year ◯ At least 1 in past 6 months

◯ At least 1 per month over past year ◯ At least 1 in 4 months over past year

3D. Has the Veteran ever had minor seizures (characterized by a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ("pure" petit mal) or sudden jerking movements of the arms, trunk or head (myoclonic type) or sudden loss of postural control (akinetic type))?

◯ Yes ◯ No

Number of minor seizures over past 6 months

◯ 0-1 ◯ 2 or more

(If 2 or more over the past 6 months, indicate the average frequency of narcoleptic episodes):

◯ 0-4 per week ◯ 5-8 per week ◯ 9-10 per week ◯ More than 10 per week

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 any conditions listed in Section I, diagnosis above?

◯ Yes ◯ No

If yes, describe (brief summary):

SECTION V - DIAGNOSTIC TESTING

NOTE - If diagnostic test results are in the medical record and reflect the Veteran's current narcolepsy condition, repeat testing is not required.

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

◯ Yes ◯ No

If yes, check all that apply:

☐ Polysomnogram (PSG) Date: _____ Results: _____

☐ Multiple Sleep Latency Test (MSLT) Date: _____ Results: _____

☐ Hypocretin level in cerebrospinal fluid (CSF) Date: _____ Results: _____

☐ Other, describe: _____ Date: _____ Results: _____

5B. 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)):

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:	