Department of Veterans Affairs

HEPATITIS, CIRRHOSIS AND OTHER LIVER CONDITIONS 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

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

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A LIVER CONDITION?

☐ YES ☐ NO (If "Yes," complete Item 1B)

1B. SELECT THE VETERAN'S CONDITION *(check all that apply):*

☐ Hepatitis A	ICD code:		Date of diagnosis:	*(complete Section III)*
☐ Hepatitis B	ICD code:		Date of diagnosis:	*(complete Section III)*
☐ Hepatitis C	ICD code:		Date of diagnosis:	*(complete Section III)*
☐ Autoimmune hepatitis	ICD code:		Date of diagnosis:	*(complete Section III)*
☐ Drug-induced hepatitis	ICD code:		Date of diagnosis:	*(complete Section III)*
☐ Hemochromatosis	ICD code:		Date of diagnosis:	*(complete Section III)*
☐ Cirrhosis of the liver	ICD code:		Date of diagnosis:	*(complete Section IV)*
☐ Primary biliary cirrhosis	ICD code:		Date of diagnosis:	*(complete Section IV)*
☐ Sclerosing cholangitis	ICD code:		Date of diagnosis:	*(complete Section IV)*
☐ Liver transplant candidate	ICD code:		Date of diagnosis:	*(complete Section V)*
☐ Liver transplant	ICD code:		Date of diagnosis:	*(complete Section V)*
☐ Other liver conditions:				
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 LIVER CONDITIONS, LIST USING ABOVE FORMAT:

NOTE: Determination of these conditions requires documentation by appropriate serologic testing, abnormal liver function tests, and/or abnormal liver biopsy or imaging tests. If test results are documented in the medical record, additional testing is not required.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including cause, onset and course)* OF THE VETERAN'S LIVER CONDITIONS *(brief summary):*

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S LIVER CONDITIONS?

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR THE LIVER CONDITIONS:

SECTION III - HEPATITIS

(Including hepatitis A, B and C, autoimmune or drug-induced hepatitis, any other infectious liver disease and chronic liver disease without cirrhosis)

3A. DOES THE VETERAN CURRENTLY HAVE SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC OR INFECTIOUS LIVER DISEASES?

☐ YES ☐ NO

IF YES, INDICATE SIGNS AND SYMPTOMS ATTRIBUTABLE TO CHRONIC OR INFECTIOUS LIVER DISEASES *(check all that apply):*

☐ Fatigue
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Malaise
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Anorexia
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Nausea
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Vomiting
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Arthralgia
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Weight loss
If checked, provide baseline weight _____ and current weight _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
Also, indicate if this weight loss has been sustained for three months or longer: ☐ YES ☐ NO

☐ Right upper quadrant pain
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Hepatomegaly

☐ Condition requires dietary restriction
If checked, describe dietary restrictions: _____

☐ Condition results in other indications of malnutrition
If checked, describe other indications of malnutrition: _____

☐ Other, describe: _____

3B. HAS THE VETERAN BEEN DIAGNOSED WITH HEPATITIS C?

☐ YES ☐ NO

IF YES, INDICATE RISK FACTORS *(check all that apply):*

☐ Unknown
☐ No known risk factors
☐ Organ transplant before 1992
☐ Transfusions of blood or blood products before 1992
☐ Hemodialysis
☐ Accidental exposure to blood by health care workers *(to include combat medic or corpsman)*
☐ Intravenous drug use or intranasal cocaine use
☐ High risk sexual activity
☐ Other direct percutaneous exposure to blood *(such as by tattooing, body piercing, acupuncture with non-sterile needles, shared toothbrushes and/or shaving razors)*
If checked, describe: _____
☐ Other, describe: _____

3C. HAS THE VETERAN HAD ANY INCAPACITATING EPISODES *(with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)* DUE TO THE LIVER CONDITIONS DURING THE PAST 12 MONTHS?

☐ YES ☐ NO

IF YES, PROVIDE THE TOTAL DURATION OF THE INCAPACITATING EPISODES OVER THE PAST 12 MONTHS:

☐ Less than 1 week
☐ At least 1 week but less than 2 weeks
☐ At least 2 weeks but less than 4 weeks
☐ At least 4 weeks but less than 6 weeks
☐ 6 weeks or more

NOTE: For VA purposes, an "incapacitating episode" means a period of acute symptoms severe enough to require bed rest and treatment by a physician.

SECTION IV - CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS AND CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS

4A. DOES THE VETERAN CURRENTLY HAVE SIGNS OR SYMPTOMS ATTRIBUTABLE TO CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS OR CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS?

☐ YES ☐ NO

IF YES, INDICATE SIGNS AND SYMPTOMS ATTRIBUTABLE TO CIRRHOSIS OF THE LIVER, BILIARY CIRRHOSIS OR CIRRHOTIC PHASE OF SCLEROSING CHOLANGITIS *(check all that apply):*

☐ Weakness
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Anorexia
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Abdominal pain
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Malaise
If checked, indicate frequency and severity: ☐ Intermittent ☐ Daily ☐ Near-constant and debilitating

☐ Weight loss
If checked, provide baseline weight: _____ and current weight: _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
Also, indicate if this weight loss has been sustained for three months or longer: ☐ YES ☐ NO

☐ Ascites
If checked, indicate frequency and severity *(check all that apply):*
☐ 1 episode ☐ 2 or more episodes ☐ Periods of remission between attacks ☐ Refractory to treatment
Date of last episode of ascites: _____

☐ Hepatic encephalopathy
If checked, indicate frequency and severity *(check all that apply):*
☐ 1 episode ☐ 2 or more episodes ☐ Periods of remission between attacks ☐ Refractory to treatment
Date of last episode of hepatic encephalopathy: _____

☐ Hemorrhage from varices or portal gastropathy *(erosive gastritis)*
If checked, indicate frequency and severity *(check all that apply):*
☐ 1 episode ☐ 2 or more episodes ☐ Periods of remission between attacks ☐ Refractory to treatment
Date of last episode of hemorrhage from varices or portal gastropathy: _____

☐ Portal hypertension

☐ Splenomegaly

☐ Persistent jaundice

SECTION V - LIVER TRANSPLANT AND/OR LIVER INJURY

5A. IS THE VETERAN A LIVER TRANSPLANT CANDIDATE?

☐ YES ☐ NO

5B. IS THE VETERAN CURRENTLY HOSPITALIZED AWAITING TRANSPLANT?

☐ YES ☐ NO

Date of hospital admission for this condition: _____

5C. HAS THE VETERAN UNDERGONE A LIVER TRANSPLANT?

☐ YES ☐ NO

Date(s) of surgery: _____ _____ _____
Date of hospital discharge: _____
Current signs and symptoms: _____

5D. HAS THE VETERAN HAD AN INJURY TO THE LIVER?

☐ YES ☐ NO

IF YES, DOES THE VETERAN HAVE PERITONEAL ADHESIONS RESULTING FROM AN INJURY TO THE LIVER?

☐ YES ☐ NO

(If "Yes," ALSO complete the Peritoneal Adhesions Questionnaire)

SECTION VI - TUMORS AND NEOPLASMS

6A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

◯ Yes ◯ No If yes, complete the following section.

6B. Is the neoplasm

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

◯ Primary ◯ Secondary (metastatic) (if secondary, indicate the primary site, if known): _____

6C. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

◯ Yes ◯ No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

☐ Treatment completed

☐ 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: _____

6D. Does the Veteran currently have any residuals or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

◯ Yes ◯ No

If yes, list residuals or complications (brief summary), and also complete the appropriate questionnaire:

6E. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the above format:

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

7A. 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*):

SECTION VII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS *(Continued)*

7B. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM *(6 square inches)*; OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

☐ YES ☐ NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: _____ MEASUREMENTS: length _____ cm X width _____ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

7C. COMMENTS, IF ANY:

SECTION VIII - DIAGNOSTIC TESTING

NOTE: Diagnosis of hepatitis C must be confirmed by recombinant immunoblot assay (RIBA). If this information is of record, repeat RIBA test is not required. If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

8A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐	EUS *(Endoscopic ultrasound)*	Date:	Results:	
☐	ERCP *(Endoscopic retrograde cholangiopancreatography)*	Date:	Results:	
☐	Transhepatic cholangiogram	Date:	Results:	
☐	MRI or MRCP *(magnetic resonance cholangiopancreatography)*	Date:	Results:	
☐	CT	Date:	Results:	
☐	Other, describe: _____	Date:	Results:	

8B. HAVE LABORATORY STUDIES BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐	Recombinant immunoblot assay *(RIBA)*	Date:	Results:	
☐	Hepatitis C genotype	Date:	Results:	
☐	Hepatitis C viral titers	Date:	Results:	
☐	AST	Date:	Results:	
☐	ALT	Date:	Results:	
☐	Alkaline phosphatase	Date:	Results:	
☐	Bilirubin	Date:	Results:	
☐	INR (PT)	Date:	Results:	
☐	Creatinine	Date:	Results:	
☐	MELD score	Date:	Results:	
☐	Other, describe: _____	Date:	Results:	

8C. HAS A LIVER BIOPSY BEEN PERFORMED?

☐ YES ☐ NO Date of test: _____ Results: _____

SECTION VIII - DIAGNOSTIC TESTING (continued)

8D. 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 IX - FUNCTIONAL IMPACT

9. DOES THE VETERAN'S LIVER CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S LIVER CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION X - REMARKS

10. REMARKS *(If any)*

SECTION XI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

11A. Examiner's signature:

11B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

11C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

11D. Date Signed:

11E. Examiner's phone/fax numbers:

11F. National Provider Identifier (NPI) number:

11G. Medical license number and state:

11H. Examiner's address: