Department of Veterans Affairs

# SPINA BIFIDA
# DISABILITY BENEFITS QUESTIONNAIRE

| Name of Veteran: | Veteran's Social Security Number: |
|---|---|
| | |

| Name of Claimant: | Claimant's Social Security Number: | Date of examination: |
|---|---|---|
| | | |

Note to examiner - This is a spina bifida examination for the natural child (claimant) of a Veteran exposed to herbicides. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the claim.

**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 claimant 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 claimant's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the claimant'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 claimant'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 claimant have a spina bifida diagnosis, to include any form or manifestation of spina bifida?

◯ Yes ◯ No If no, explain your findings and reasons in the remarks section.

1B. If yes, please check the spina bifida type.

| | | | | |
|---|---|---|---|---|
| ☐ | Spina bifida occulta (If this is the only type, completion of the remainder of this questionnaire is not required.) | ICD code | | Date of diagnosis |
| ☐ | Meningocele | ICD code | | Date of diagnosis |
| ☐ | Myelomeningocele | ICD code | | Date of diagnosis |

☐ Other form or manifestation of spina bifida (if checked, specify below using the above format)

## SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the claimant's spina bifida. Brief summary:

2B. Has the claimant undergone any surgical procedures for any of the spina bifida types selected in Section I?

◯ Yes ◯ No

If yes, identify type of surgical procedure: Date of surgical procedure:

If there are additional surgical procedures, list using the above format:

## SECTION III - LOCOMOTION

3A. Please indicate the claimant's primary means of locomotion.

☐ The claimant walks without braces or other external support as his or her primary means of mobility in the community.

☐ The claimant walks with braces or other external support as his or her primary means of mobility in the community.

☐ The claimant uses a wheelchair as his or her primary means of mobility in the community.

3B. Does the claimant have a medical condition that is unrelated to spina bifida that contributes to the impaired locomotion?

◯ Yes ◯ No

3C. If yes, can the impairment be differentiated from the impairment attributable to spina bifida?

◯ Yes ◯ No

If yes, identify the condition(s) and describe the impact for each condition affecting locomotion.

## SECTION IV - IMPAIRMENT OF THE UPPER EXTREMITIES

4A. Does the claimant have sensory or motor impairment of the upper extremities?

◯ Yes ◯ No

If yes, indicate whether the sensory or motor impairment of the upper extremities is severe enough to prevent any of the following tasks:

Grasp a pen ◯ Yes ◯ No

Feed self ◯ Yes ◯ No

Perform self-care ◯ Yes ◯ No

4B. Does the claimant have a medical condition that is unrelated to spina bifida that contributes to the impairment of the upper extremities?

◯ Yes ◯ No

4C. If yes, can the impairment be differentiated from the impairment attributable to spina bifida?

◯ Yes ◯ No

If yes, identify the condition(s) and describe the impact for each condition affecting the upper extremities.

## SECTION V - INTELLIGENCE QUOTIENT (IQ)

5A. Please indicate the claimant's IQ based upon records reviewed.

- ☐ The claimant has an IQ of 90 or higher.
- ☐ The claimant has an IQ of at least 70 but less than 90.
- ☐ The claimant has an IQ of 69 or less.
- ☐ The claimant's IQ is unknown based on the available records reviewed.

5B. Provide the name and date of the document/record the response to 5A is based upon.

## SECTION VI - URINARY CONTINENCE

6A. Please indicate the claimant's level of urinary continence.

- ☐ The claimant is continent of urine without the use of medication or other means to control incontinence.
- ☐ The claimant requires medication or other means to control the effects of urinary bladder impairment and no more than two times per week is unable to remain dry for at least three hours at a time during waking hours.
- ☐ The claimant, despite the use of medication or other means to control the effects of urinary bladder impairment, at least three times per week is unable to remain dry for three hours at a time during waking hours.

6B. Does the claimant have a medical condition that is unrelated to spina bifida that contributes to the urinary incontinence?

◯ Yes ◯ No

6C. If yes, can the impairment be differentiated from the impairment attributable to spina bifida?

◯ Yes ◯ No

If yes, identify the condition(s) and describe the impact for each condition affecting the urinary incontinence.

## SECTION VII - BOWEL CONTINENCE

7A. Please indicate the claimant's level of bowel continence.

- ☐ The claimant is continent of feces without the use of medication or other means to control incontinence.
- ☐ The claimant requires bowel management techniques or other treatment to control the effects of bowel impairment but does not have fecal leakage severe or frequent enough to require wearing absorbent materials at least four days a week.
- ☐ The claimant has had a colostomy that does not require wearing a bag.
- ☐ The claimant, despite bowel management techniques or other treatment to control the effects of bowel impairment, has fecal leakage severe or frequent enough to require wearing of absorbent materials at least four days a week.
- ☐ The claimant regularly requires manual evacuation or digital stimulation to empty the bowel.
- ☐ The claimant has had a colostomy that requires wearing a bag.

7B. Does the claimant have a medical condition that is unrelated to spina bifida that contributes to the bowel incontinence?

◯ Yes ◯ No

7C. If yes, can the impairment be differentiated from the impairment attributable to spina bifida?

◯ Yes ◯ No

If yes, identify the condition(s) and describe the impact for each condition affecting the bowel incontinence.

## SECTION VIII - OTHER PERTINENT FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, OR DISABILITIES

8A. Does the claimant have any other pertinent findings, complications, conditions, signs, symptoms or disabilities such as blindness, uncontrolled seizures, or renal failure related to any conditions listed in the diagnosis section above?

◯ Yes ◯ No If yes, identify the disabilities and describe the resulting functional impairment, including the impact on the claimant's ability to engage in ordinary day-to-day activities. Additional questionnaires are not required for this examination.

## SECTION IX - DIAGNOSTIC TESTING

**NOTE:** If imaging studies, diagnostic procedures or laboratory testing have been performed, provide the most recent results. Additional diagnostic testing is not required for this examination.

9A. Are there relevant diagnostic test findings and/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 X - FINANCIAL RESPONSIBILITY

10A. In your judgment, is the claimant able to manage his/her benefit payments in his/her own best interest, or able to direct someone else to do so?

◯ Yes ◯ No ◯ N/A, child under the age of 18

If no, provide an explanation.

## 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.

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: