Department of Veterans Affairs

ESOPHAGEAL CONDITIONS (INCLUDING GASTROESOPHAGEAL REFLUX DISEASE (GERD), HIATAL HERNIA, AND OTHER ESOPHAGEAL DISORDERS) 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:

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different

from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition(s), explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

- ☐ The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. (Explain your findings and reasons in the Remarks section)
- ☐ Hiatal hernia — ICD code: _____ Date of diagnosis: _____
- ☐ Gastroesophageal reflux disease (GERD) * — ICD code: _____ Date of diagnosis: _____
- ☐ Paraesophageal hernia — ICD code: _____ Date of diagnosis: _____
- ☐ Esophagus, stricture of — ICD code: _____ Date of diagnosis: _____
- ☐ Esophagitis (specify type):

  _____ ICD code: _____ Date of diagnosis: _____
- ☐ Barrett's esophagus — ICD code: _____ Date of diagnosis: _____
- ☐ Mallory Weiss syndrome/tear — ICD code: _____ Date of diagnosis: _____
- ☐ Esophageal motility disorder (select one if known) — ICD code: _____ Date of diagnosis: _____
  - ☐ Achalasia (cardiospasm) — ICD code: _____ Date of diagnosis: _____
  - ☐ Diffuse esophageal spasm — ICD code: _____ Date of diagnosis: _____
  - ☐ Corkscrew esophagus — ICD code: _____ Date of diagnosis: _____
  - ☐ Nutcracker esophagus — ICD code: _____ Date of diagnosis: _____
  - ☐ Other motor/motility disorders of the esophagus (specify type):

    _____ ICD code: _____ Date of diagnosis: _____
- ☐ Esophageal rings (including Schatzki rings) — ICD code: _____ Date of diagnosis: _____
- ☐ Disorder of esophageal mucosal webs — ICD code: _____ Date of diagnosis: _____
- ☐ Disorder of esophageal mucosal folds — ICD code: _____ Date of diagnosis: _____
- ☐ Esophagus impairment caused by systemic condition (specify condition):

  _____ ICD code: _____ Date of diagnosis: _____
- ☐ Esophagus, diverticulum of, acquired — ICD code: _____ Date of diagnosis: _____
  - ☐ Pharyngoesophageal (Zenker's) diverticulum — ICD code: _____ Date of diagnosis: _____
  - ☐ Mid-esophageal diverticulum — ICD code: _____ Date of diagnosis: _____
  - ☐ Epiphrenic (distal esophagus) diverticulum — ICD code: _____ Date of diagnosis: _____
- ☐ Esophageal cancer — ICD code: _____ Date of diagnosis: _____
- ☐ Benign neoplasm of the esophagus (if checked specify):

  _____ ICD code: _____ Date of diagnosis: _____
- ☐ Other esophageal condition(s) (specify):

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

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

Other diagnosis #3: _____ ICD code: _____ Date of diagnosis: _____

* Note: The diagnosis of gastroesophageal reflux disease (GERD) can be made clinically by evidence of relief of typical symptoms of reflux, epigastric discomfort and/or burning, by treatment with proton pump inhibitors, histamine 2 receptor antagonists and/or antacids. If upper endoscopy was indicated or performed, the findings of erythema, ulcers and/or strictures are consistent with the diagnosis of GERD.

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

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's esophageal condition(s). Brief summary:

2B. Does the Veteran's treatment plan include taking daily prescribed medication for the diagnosed condition(s)?

◯ Yes ◯ No

If yes, list only those medications used for the diagnosed condition(s):

SECTION III - SIGNS AND SYMPTOMS

3A. Does the Veteran have any of the following signs, symptoms, or treatment requirements due to any esophageal condition(s) (including GERD and hiatal hernia)?

◯ Yes ◯ No

If yes, check all that apply:

☐ Without daily symptoms

☐ Without requirement for daily medication

☐ Dysphagia (difficulty swallowing)

☐ Requiring daily medication to control dysphagia

☐ Documented history of esophageal stricture(s) (see Note 1) (If checked indicate if recurrent or refractory)

Note 1: Findings must be documented by barium swallow, computerized tomography (CT), or esophagogastroduodenoscopy (EGD). (Indicate date of study in Section VI)

Has the esophageal stricture(s) been recurrent or refractory? (see Note 2)

◯ Yes ◯ No

Note 2: Recurrent esophageal stricture is defined as the inability to maintain target esophageal diameter beyond 4 weeks after the target diameter has been achieved. Refractory esophageal stricture is defined as the inability to achieve target esophageal diameter despite receiving no fewer than 5 dilatation sessions performed at 2-week intervals.

☐ Requiring dilatation (if checked indicate frequency and list most recent dates):

◯ No more than 2 times a year ◯ 3 or more times a year

Was there dilatation utilizing steroids at least 1 time per year?

◯ Yes ◯ No

Date of dilatation: _____ Date of dilatation: _____ Date of dilatation: _____

☐ Requiring esophageal stent placement (see 3C)

☐ Aspiration

☐ Undernutrition (see Note 3)

☐ Substantial weight loss (see Note 4)

☐ Treatment with surgical correction (see 3C and 3D)

☐ Treatment with a percutaneous esophago-gastrointestinal tube (PEG tube) (see 3C and 3D)

☐ Other, symptom(s) specify:

_____

Note 3: "Undernutrition" means a deficiency resulting from insufficient intake of one or multiple essential nutrients, or the inability of the body to absorb, utilize, or retain such nutrients. Undernutrition is characterized by failure of the body to maintain normal organ functions and healthy tissues. Signs and symptoms may include: loss of subcutaneous tissue, edema, peripheral neuropathy, muscle wasting, weakness, abdominal distention, ascites, and Body Mass Index below normal range.

Note 4: "Substantial weight loss" means involuntary loss greater than 20 percent of an individual's baseline weight sustained for three months with diminished quality of self-care or work tasks. "Baseline weight" means the clinically documented average weight for the two-year period preceding the onset of illness or, if relevant, the weight recorded at the Veteran's most recent discharge physical. If neither of these weights is available or currently relevant, then use ideal body weight as determined by either the Hamwi formula or Body Mass Index tables, whichever is most favorable to the Veteran.

3B. Does the Veteran have Barrett's esophagus documented by pathologic diagnosis? (if yes, please answer remainder of questions in 3B)

◯ Yes ◯ No

Specify severity of dysplasia (Indicate date of biopsy in Section VI):

◯ High-grade dysplasia ◯ Low-grade dysplasia ◯ No dysplasia

Did Barrett's esophagus cause esophageal stricture(s)?

◯ Yes ◯ No

Has the condition been resolved via surgery, radiofrequency ablation, or other treatment? (If yes, give type of procedure and date)

◯ Yes ◯ No

Surgery/procedure type and date: _____

3C. Did the Veteran have surgery or other procedure performed for an esophageal condition(s) (other than Barret's esophagus) or hiatal hernia? (if yes, give type(s) and date(s))

◯ Yes ◯ No

Surgery/procedure type and date _____ Surgery/procedure type and date _____

3D. Does the Veteran have chronic complications of esophageal or hiatal hernia surgery?

◯ Yes ◯ No If yes, check all that apply (if appropriate):

☐ Post-operative, asymptomatic

☐ Requiring continuous total parenteral nutrition (TPN) for a period longer than 30 consecutive days in the last six months.

If checked list dates: Start date of TPN: _____ Completion date of TPN or anticipated date of completion: _____

☐ Requiring continuous tube feeding for a period longer than 30 consecutive days in the last six months.

If checked list dates: Start date of tube feeding: _____ Completion date of tube feeding or anticipated date of completion: _____

☐ Vomiting (if checked indicate frequency and if managed by medical treatment, oral dietary modification, or medication)

Frequency:

◯ Less than 2 times a week ◯ 2 or more times a week ◯ Daily

Treatment:

◯ No treatment

◯ Managed by ongoing medical treatment

◯ Vomiting despite medical treatment (check all that apply):

☐ Oral dietary modification

☐ Medication

☐ Other (specify): _____

☐ Watery bowel movements (if checked indicate frequency):

◯ Less than 3 per day every day ◯ 3-5 per day every day ◯ 6 or more per day every day

☐ Explosive bowel movements that are difficult to predict or control

☐ Nausea (if checked indicate if managed by medical treatment):

Managed by ongoing medical treatment? ◯ Yes ◯ No

☐ Post-prandial (meal-induced) light-headedness (syncope) with sweating

☐ Requirement for medications to specifically treat complications of upper GI surgery including dumping syndrome or delayed gastric emptying

☐ Discomfort or pain within an hour of eating and requiring ongoing oral dietary modification

☐ Other, symptom(s) specify: _____

SECTION IV - TUMORS AND NEOPLASMS

4A. 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.

4B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

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

4C. 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: _____

4D. 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:

4E. 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 V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND OR SYMPTOMS, AND SCARS

5A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any condition(s) listed in the diagnosis section above?

◯ Yes ◯ No If yes, describe (brief summary):

5B. Does the Veteran have any scars or other disfigurement (of the skin) related to any condition(s) or to the treatment of any condition(s) listed in the diagnosis section?

◯ Yes ◯ No If yes, also complete the appropriate dermatological questionnaire.

SECTION VI - DIAGNOSTIC TESTING

Note: If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report. Esophageal stricture must be documented by barium swallow, CT, or EGD.

6A. 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.

☐ EGD		Date:	Results:	
☐ Upper GI radiographic studies		Date:	Results:	
☐ Barium swallow		Date:	Results:	
☐ MRI		Date:	Results:	
☐ CT		Date:	Results:	
☐ Biopsy, specify site:		Date:	Results:	
☐ Other, specify:		Date:	Result:	

6B. Has clinically relevant laboratory testing been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, check all that apply.

☐ CBC Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

☐ Other, specify: _____ Date of test: _____ Results: _____

6C. 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):

6D. If any test result results are other than normal, indicate relationship of abnormal findings to diagnosed condition.

SECTION VII - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

7A. 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 VIII - REMARKS

8A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION IX - 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.

9A. Examiner's signature:	9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	9D. Date Signed:

9E. Examiner's phone/fax numbers:	9F. National Provider Identifier (NPI) number:	9G. Medical license number and state:

9H. Examiner's address: