Department of Veterans Affairs

GALLBLADDER CONDITIONS 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 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

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 conditions listed above. (Explain your findings and reasons in the Remarks section)

☐ Cholecystectomy (gallbladder removal) ICD Code: _____ Date of Diagnosis: _____

☐ Cholelithiasis, chronic ICD Code: _____ Date of Diagnosis: _____

☐ Chronic Biliary tract disease ICD Code: _____ Date of Diagnosis: _____

(select if known)

☐ Bile duct injury ICD Code: _____ Date of Diagnosis: _____

☐ Biliary stricture ICD Code: _____ Date of Diagnosis: _____

☐ Cholangitis (other than primary sclerosing cholangitis) ICD Code: _____ Date of Diagnosis: _____

☐ Cholecystitis, chronic ICD Code: _____ Date of Diagnosis: _____

☐ Choledochal cyst ICD Code: _____ Date of Diagnosis: _____

☐ Sphincter of Oddi dysfunction ICD Code: _____ Date of Diagnosis: _____

☐ Other: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Gallbladder cancer ICD Code: _____ Date of Diagnosis: _____

☐ Gallbladder neoplasm, benign ICD Code: _____ Date of Diagnosis: _____

☐ Gallbladder injury ICD Code: _____ Date of Diagnosis: _____

☐ Other gallbladder conditions:

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

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

Other diagnosis #3 _____ ICD Code: _____ Date of Diagnosis: _____

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

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's gallbladder condition (brief summary):

2B. Is continuous medication prescribed by a medical provider required for control of the Veteran's gallbladder condition? ◯ Yes ◯ No

If yes, list only those medications for the gallbladder condition:

SECTION III - GALLBLADDER AND BILIARY TRACT CONDITIONS

3A. Does the Veteran have chronic gallbladder and/or biliary tract disease? ◯ Yes ◯ No

If yes, check all that apply:

☐ Asymptomatic, without history of a clinically documented attack of right upper quadrant pain with nausea and vomiting in the past 12 months

☐ Clinically documented attacks of right upper quadrant pain in the past 12 months (indicate the number of attacks and symptoms)

Number of attacks:

◯ 1 or 2

◯ 3 or more

Symptoms:

☐ Indicates nausea

☐ Includes vomiting

For each occurrence, provide date(s) of clinically documented attacks below:

☐ Requiring dilatation of biliary tract strictures at least once during the past 12 months

☐ Other signs or symptoms, describe:

3B. Does the Veteran have a gallbladder injury? ◯ Yes ◯ No

If yes, check all that apply:

☐ Asymptomatic

☐ Diarrhea

☐ Constipation

☐ Colic

☐ Vomiting

☐ Nausea

☐ Abdominal pain

☐ Medically directed dietary modification other than total parenteral nutrition (TPN)

☐ Persistent partial bowel obstruction

Is the persistent partial bowel obstruction inoperable? ◯ Yes ◯ No

Is the persistent partial bowel obstruction refractory to treatment? ◯ Yes ◯ No

Does the persistent partial bowel obstruction require TPN for obstructive symptoms? ◯ Yes ◯ No

☐ Clinical evidence of recurrent obstruction requiring hospitalization at least once a year (as shown and documented in the Veteran's health record(s)). If checked, also complete Question 3E.

3C. Has the Veteran had a Cholecystectomy (gallbladder removal)? ◯ Yes ◯ No

If yes, indicate symptoms (check all that apply):

☐ Asymptomatic

☐ Intermittent abdominal pain

☐ Recurrent abdominal pain (post-prandial or nocturnal)

☐ Diarrhea (select frequency below)

◯ Characterized by one to two watery bowel movements per day

◯ Chronic diarrhea characterized by three or more watery bowel movements per day

☐ Other signs or symptoms, describe:

Date of surgery: _____ Indicate facility: _____

3D. Has the Veteran had other surgical procedure(s) for a gallbladder condition? ◯ Yes ◯ No

If yes, describe the surgical procedure(s) below:

Date of surgery: _____ Indicate facility: _____

3E. Has the Veteran had any hospitalizations for the treatment of, or complications resulting from a gallbladder condition in the past 24 months? ◯ Yes ◯ No

If yes, complete the following:

Date of admission: _____ Indicate facility: _____

If there are additional hospitalizations, list using above format:

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, SYMPTOMS, AND SCARS

5A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions 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 conditions or to the treatment of any conditions listed in the diagnosis section?

◯ Yes ◯ No

If yes, also complete the appropriate dermatological questionnaire.

5C. Comments:

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.

6A. Have clinically relevant imaging studies been performed or reviewed in conjunction with this examination?

◯ 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:
☐	Gallbladder scan (HIDA scan or cholescintigraphy)	Date:		Results:
☐	CT	Date:		Results:
☐	Other, specify: _____	Date:		Results:

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

◯ Yes ◯ No

If yes, check all that apply:

☐	Alkaline phosphatase	Date:		Results:
☐	Bilirubin	Date:		Results:
☐	WBC	Date:		Results:
☐	Amylase	Date:		Results:
☐	Lipase	Date:		Results:
☐	Other, specify: _____	Date:		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 in a brief summary:

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

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.

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:		