



**INTESTINAL CONDITIONS (OTHER THAN SURGICAL OR INFECTIOUS)  
(INCLUDING IRRITABLE BOWEL SYNDROME, CROHN'S DISEASE, ULCERATIVE COLITIS,  
AND DIVERTICULITIS) DISABILITY BENEFITS QUESTIONNAIRE**

**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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
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**NOTE TO PHYSICIAN** - Your patient 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.

**SECTION I - DIAGNOSIS**

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN INTESTINAL CONDITION (*other than surgical or infectious*)?

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

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

<input type="checkbox"/> IRRITABLE BOWEL SYNDROME	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> SPASTIC COLITIS	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> MUCOUS COLITIS	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> CHRONIC DIARRHEA	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> ULCERATIVE COLITIS	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> CROHN'S DISEASE	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> CHRONIC ENTERITIS	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> CHRONIC ENTEROCOLITIS	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> CELIAC DISEASE	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> DIVERTICULITIS	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> INTESTINAL NEOPLASM	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> PERITONEAL ADHESIONS ATTRIBUTABLE TO DIVERTICULITIS. <small>IF CHECKED, ALSO COMPLETE VA Form 21-0960G-6, <i>Peritoneal Adhesions Disability Benefits Questionnaire</i></small>	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> OTHER NON-SURGICAL OR NON-INFECTIOUS INTESTINAL 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 INTESTINAL CONDITIONS (*other than surgical or infectious*), LIST USING THE FORMAT IN ITEM 1B

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S INTESTINAL CONDITION (*Brief summary*)

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S INTESTINAL CONDITION?

YES  NO

IF YES, LIST ONLY THOSE MEDICATIONS REQUIRED FOR THE INTESTINAL CONDITION

2C. HAS THE VETERAN HAD SURGICAL TREATMENT FOR AN INTESTINAL CONDITION?

YES  NO

IF YES, ALSO COMPLETE VA FORM 21-0960G-4, INTESTINAL SURGERY (BOWEL RESECTION, COLOSTOMY, ILEOSTOMY) DISABILITY BENEFITS QUESTIONNAIRE

**SECTION III - SIGNS AND SYMPTOMS**

3. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY NON-SURGICAL NON-INFECTIOUS INTESTINAL CONDITION(S)?

YES  NO (If "Yes," check all that apply)

DIARRHEA (If checked, describe)

\_\_\_\_\_

ALTERNATING DIARRHEA AND CONSTIPATION (If checked, describe)

\_\_\_\_\_

ABDOMINAL DISTENSION (If checked, describe)

\_\_\_\_\_

ANEMIA (If checked, provide hemoglobin/hematocrit in Section IX, Diagnostic Testing)

NAUSEA (If checked, describe)

\_\_\_\_\_

VOMITING (If checked, describe)

\_\_\_\_\_

OTHER (If checked, describe)

**SECTION IV - SYMPTOM EPISODES, ATTACKS AND EXACERBATIONS**

4. DOES THE VETERAN HAVE EPISODES OF BOWEL DISTURBANCE WITH ABDOMINAL DISTRESS, OR EXACERBATIONS OR ATTACKS OF THE INTESTINAL CONDITION?

YES  NO

IF YES, INDICATE SEVERITY AND FREQUENCY (Check all that apply)

Episodes of bowel disturbance with abdominal distress

If checked, indicate frequency

Occasional episodes

Frequent episodes

More or less constant abdominal distress

Episodes of exacerbations and/or attacks of the intestinal condition. If checked, describe typical exacerbation or attack

Indicate number of exacerbations and/or attacks in past 12 months

1  2  3  4  5  6  7 or more

**SECTION V - WEIGHT LOSS**

5. DOES THE VETERAN HAVE WEIGHT LOSS ATTRIBUTABLE TO AN INTESTINAL CONDITION (other than surgical or infectious condition)?

YES  NO

If "Yes," provide veteran's baseline weight: \_\_\_\_\_ and current weight: \_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

**SECTION VI - MALNUTRITION, COMPLICATIONS AND OTHER GENERAL HEALTH EFFECTS**

6. DOES THE VETERAN HAVE MALNUTRITION, SERIOUS COMPLICATIONS OR OTHER GENERAL HEALTH EFFECTS ATTRIBUTABLE TO THE INTESTINAL CONDITION?

YES  NO (If "Yes," indicate findings) (Check all that apply)

Health only fair during remissions

General debility

Serious complication such as liver abscess (Describe)

\_\_\_\_\_

Malnutrition. If checked, is malnutrition marked?  YES  NO

Other (Describe) \_\_\_\_\_

**NOTE:** Complete additional Disability Benefits Questionnaire(s) for complications noted, as deemed appropriate (schedule with appropriate provider).

**SECTION VII - TUMORS AND NEOPLASMS**

7A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS?

YES  NO (If "Yes," complete questions 7B thru 7E)

7B. IS THE NEOPLASM?

BENIGN  MALIGNANT

7C. 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, currently in watchful waiting status

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 \_\_\_\_\_

7D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (including metastases) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN ITEM 7C?

YES  NO IF YES, LIST RESIDUAL CONDITIONS AND COMPLICATIONS (Brief summary)

7E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE FORMAT IN ITEMS 7C AND 7D

**SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS**

8A. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS

YES  NO

IF YES, ARE ANY OF THE SCARS PAINFUL AND/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN OR EQUAL TO 39 SQUARE cm (6 square inches)?

YES  NO

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

8B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

YES  NO

IF YES, DESCRIBE (Brief summary)

**SECTION IX - DIAGNOSTIC TESTING**

**NOTE:** If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the veteran's current condition, provide most recent results; no further studies or testing are required for this examination.

9A. HAS LABORATORY TESTING BEEN PERFORMED?

YES  NO (If "Yes," check all that apply)

CBC (If anemia due to any intestinal condition is suspected or present)

Date of test: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ Hematocrit: \_\_\_\_\_ White blood cell count: \_\_\_\_\_ Platelets: \_\_\_\_\_

Other (Specify) \_\_\_\_\_

Date of test: \_\_\_\_\_

Results: \_\_\_\_\_

9B. HAVE IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (Brief summary)

9C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES  NO IF YES, DESCRIBE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (Brief summary)

**SECTION X - FUNCTIONAL IMPACT**

10. DOES THE VETERAN'S INTESTINAL CONDITION IMPACT HIS OR HER ABILITY TO WORK?

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

**SECTION XI - REMARKS**

11. REMARKS (If any)

**SECTION XII - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

12A. PHYSICIAN'S SIGNATURE

12B. PHYSICIAN'S PRINTED NAME

12C. DATE SIGNED

12D. PHYSICIAN'S PHONE AND FAX NUMBER

12E. PHYSICIAN'S MEDICAL LICENSE NUMBER

12F. PHYSICIAN'S ADDRESS

**NOTE** - VA may obtain additional medical information, including additional examinations if necessary to complete VA's review of the veteran's application.

**IMPORTANT** - Physician please fax the completed form to:

\_\_\_\_\_ (VA Regional Office FAX No.)

**NOTE** - A list of VA Regional Office FAX Numbers can be found at [www.benefits.va.gov/disabilityexams](http://www.benefits.va.gov/disabilityexams) or obtained by calling 1-800-827-1000.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

**RESPONDENT BURDEN:** We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete a form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at [www.reginfo.gov/public/do/PRAMain](http://www.reginfo.gov/public/do/PRAMain). If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.