OMB Approved No. 2900-0778
Respondent Burden: 15 Minutes
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Department of Veterans Affairs

OSTEOMYELITIS 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 *(First, Middle Initial, Last)*

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH OSTEOMYELITIS? ☐ YES ☐ NO *(If "No," complete Item 1B)*

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. 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, 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 is determined through record review or reported history.

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO OSTEOMYELITIS

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO OSTEOMYELITIS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

2B. INDICATE LOCATION OF INITIAL INFECTION *(Check all that apply)*:

☐ PELVIS
☐ CERVICAL VERTEBRAE
☐ THORACOLUMBAR VERTEBRAE
☐ LONG BONES OF UPPER EXTREMITY Side affected: ☐ Right ☐ Left
☐ LONG BONES OF LOWER EXTREMITY Side affected: ☐ Right ☐ Left
☐ FINGER(S): ☐ Right digit(s) affected: _____ ☐ Left digit(s) affected: _____
☐ TOE(S): ☐ Right digit(s) affected: _____ ☐ Left digit(s) affected: _____
☐ OTHER, Specify: _____

☐ EXTENSION INTO JOINTS *(If checked, indicate joints affected):*

RIGHT: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Multiple hand joints ☐ Multiple foot joints

LEFT: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Multiple hand joints ☐ Multiple foot joints

☐ OTHER, Specify: _____

2C. HAS THE VETERAN HAD MEDICAL TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING MEDICAL TREATMENT FOR OSTEOMYELITIS?

☐ YES ☐ NO

(If "Yes," describe treatment): _____

Date treatment started: _____

Date treatment completed or anticipated date of completion: _____

2D. HAS THE VETERAN HAD SURGICAL TREATMENT FOR OSTEOMYELITIS?

☐ YES ☐ NO

(If "Yes," indicate surgical procedure and date (if multiple procedures, indicate below)):

Procedure #1: _____
Date: _____ Facility: _____

Procedure #2: _____
Date: _____ Facility: _____

If additional surgical procedures, list using above format: _____

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SECTION II - MEDICAL HISTORY *(continued)*

2E. PROVIDE STATUS OF THE VETERAN'S CURRENT OSTEOMYELITIS CONDITION:

☐ ACUTE ☐ SUBACUTE ☐ CHRONIC ☐ INACTIVE ☐ RESOLVED ☐ OTHER describe: _____

SECTION III - RECURRENT INFECTIONS

3A. HAS THE VETERAN HAD ANY ADDITIONAL EPISODES OR RECURRING INFECTIONS OF OSTEOMYELITIS FOLLOWING THE INITIAL INFECTION?

☐ YES ☐ NO *(If "Yes," complete questions 3B and 3C) (If "No," skip to Section IV) (If "Yes," indicate number of additional episodes):* ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

3B. LOCATION OF RECURRENT INFECTIONS *(check all that apply)*:

☐ PELVIS
☐ CERVICAL VERTEBRAE
☐ THORACOLUMBAR VERTEBRAE
☐ LONG BONES OF UPPER EXTREMITY Side affected: ☐ Right ☐ Left
☐ LONG BONES OF LOWER EXTREMITY Side affected: ☐ Right ☐ Left
☐ FINGER(S): ☐ Right digit(s) affected: _____ ☐ Left digit(s) affected: _____
☐ TOE(S): ☐ Right digit(s) affected: _____ ☐ Left digit(s) affected: _____
☐ OTHER, Specify: _____
☐ EXTENSION INTO JOINTS
(If checked, indicate joints affected):
Right: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle
☐ Multiple hand joints ☐ Multiple foot joints
Left: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle
☐ Multiple hand joints ☐ Multiple foot joints
☐ OTHER, Specify: _____

3C. DATES OF RECURRENT INFECTION

Indicate dates of recurrences:

Date of recurrence #1: _____ Site of recurrent infection: _____
Date of recurrence #2: _____ Site of recurrent infection: _____
Date of recurrence #3: _____ Site of recurrent infection: _____

If there are additional recurrences, list using above format: _____

SECTION IV - SIGNS, SYMPTOMS AND FINDINGS

4A. DOES THE VETERAN CURRENTLY HAVE ANY SIGNS OR FINDINGS ATTRIBUTABLE TO OSTEOMYELITIS OR TREATMENT FOR OSTEOMYELITIS?

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

☐ Involucrum
☐ Sequestrum
☐ Discharging sinus
☐ Amyloidosis secondary to chronic infection
☐ Anemia
(If checked, provide CBC results in diagnostic testing section).
☐ Decreased joint function or range of motion due to osteomyelitis or residuals of treatment
If checked, indicate affected joints and ALSO complete appropriate Questionnaire for each affected joint and/or spinal segment.
Right: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Single foot joint
☐ Multiple hand joints ☐ Multiple foot joints ☐ Single hand joint
Left: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Single foot joint
☐ Multiple hand joints ☐ Multiple foot joints ☐ Single hand joint
☐ Cervical vertebral joint(s) ☐ Thoracolumbar vertebral joint(s) Specific vertebral joint(s) affected _____

4B. DOES THE VETERAN CURRENTLY HAVE ANY SYMPTOMS ATTRIBUTABLE TO OSTEOMYELITIS OR TREATMENT FOR OSTEOMYELITIS?

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

☐ Pain *(If checked, describe severity, duration and location)*: _____
☐ Swelling *(If checked, describe severity, duration and location)*: _____
☐ Tenderness *(If checked, describe severity, duration and location)*: _____
☐ Erythema *(If checked, describe severity, duration and location)*: _____
☐ Warmth *(If checked, describe severity, duration and location)*: _____
☐ Malaise *(If checked, describe symptoms and duration)*: _____
☐ Other Symptoms, describe: _____

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SECTION V - AMPUTATION

5. HAS THE VETERAN HAD AN AMPUTATION DUE TO OSTEOMYELITIS?

☐ YES ☐ NO *(If "Yes," also complete VA Form 21-0960M-1 Amputations Disability Benefits Questionnaire)*

SECTION VI - ASSISTIVE DEVICES

6A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

☐ YES ☐ NO

(If "Yes," identify assistive devices used (check all that apply and indicate frequency):

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

_____

_____

(If the veteran uses any assistive devices, specify the condition and identify the assitive device used for each condition):

SECTION VII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

7. DUE TO THE VETERAN'S OSTEOMYELITIS OR RESIDUALS OF TREATMENTS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTION REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)*

☐ YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLY SERVE THE VETERAN

☐ NO

(If "Yes," indicate extremities for which this applies):

☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples *(brief summary)*

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 THE DIAGNOSIS SECTION?

☐ 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.)
(If "No,' provide location and measurements of scar in centimeters.)

Location: _____

Measurements: Length_____ cm X width _____cm.

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the Remarks section below. It is not necessary to also complete a Scars DBQ.

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

8B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO *(If "Yes," describe (brief summary)):*

SECTION IX - DIAGNOSTIC TESTING

9A. HAVE IMAGING OR LABORATORY STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," indicate tests performed, dates and results):

☐ Bone scan	Date of test: _____	Results: _____
☐ X-ray	Date of test: _____	Results: _____
☐ MRI	Date of test: _____	Results: _____
☐ Complete blood count (CBC)	Date of test: _____	Results: _____
☐ C-reactive protein (CRP)	Date of test: _____	Results: _____
☐ Erythrocyte sedimentation rate (ESR)	Date of test: _____	Results: _____
☐ Blood culture	Date of test: _____	Results: _____
☐ Bone biopsy and culture	Date of test: _____	Results: _____
☐ Other, describe: _____	Date of test: _____	Results: _____

9B. 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 X - FUNCTIONAL IMPACT

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

☐ YES ☐ NO *(If "Yes," describe the impact of the veteran's osteomyelitis or residuals of treatment, 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. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	12F. PHYSICIAN'S ADDRESS

NOTE - VA may request 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** 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, 58/VA21/22/28, 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 the 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**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.