Department of Veterans Affairs

INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS, CHRONIC FATIGUE SYNDROME, OR TUBERCULOSIS) DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN INFECTIOUS DISEASE?

☐ YES ☐ NO If "Yes," complete Item 1B

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

☐	BARTONELLOSIS	ICD code:		Date of diagnosis:
☐	BRUCELLOSIS	ICD code:		Date of diagnosis:
☐	CAMPYLOBACTER JEJUNI INFECTION	ICD code:		Date of diagnosis:
☐	COXIELLA BURNETII INFECTION (Q FEVER)	ICD code:		Date of diagnosis:
☐	HEMORRHAGIC FEVERS, INCLUDING DENGUE, YELLOW FEVER, AND OTHERS	ICD code:		Date of diagnosis:
☐	HYPERINFECTION SYNDROME OR DISSEMINATED STRONGYLOIDIASIS	ICD code:		Date of diagnosis:
☐	LEPROSY	ICD code:		Date of diagnosis:
☐	LYME DISEASE	ICD code:		Date of diagnosis:
☐	LYMPHATIC FILARIASIS, TO INCLUDE ELEPHANTIASIS	ICD code:		Date of diagnosis:
☐	MALARIA	ICD code:		Date of diagnosis:
☐	MELIOIDOSIS	ICD code:		Date of diagnosis:
☐	MILIARY TUBERCULOSIS	ICD code:		Date of diagnosis:
☐	NONTUBERCULOSIS MYCOBACTERIAL INFECTION (NTM)	ICD code:		Date of diagnosis:
☐	NONTYPHOID SALMONELLA INFECTIONS	ICD code:		Date of diagnosis:
☐	PARASITIC DISEASE OTHERWISE NOT SPECIFIED	ICD code:		Date of diagnosis:
☐	PLAGUE	ICD code:		Date of diagnosis:
☐	RELAPSING FEVER	ICD code:		Date of diagnosis:
☐	RHEUMATIC FEVER	ICD code:		Date of diagnosis:
☐	RICKETTSIAL, EHRLICHIA, AND ANAPLASMA INFECTIONS	ICD code:		Date of diagnosis:
☐	SCHISTOSOMIASIS	ICD code:		Date of diagnosis:
☐	SHIGELLA INFECTIONS	ICD code:		Date of diagnosis:
☐	SYPHILIS	ICD code:		Date of diagnosis:
☐	VIBRIOSIS (CHOLERA)	ICD code:		Date of diagnosis:
☐	VISCERAL LEISHMANIASIS	ICD code:		Date of diagnosis:
☐	WEST NILE VIRUS INFECTION	ICD code:		Date of diagnosis:
☐	OTHER (specify):			

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 INFECTIOUS DISEASES, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S INFECTIOUS DISEASE CONDITION(S) (brief summary):

SECTION III - STATUS, SYMPTOMS, AND RESIDUALS

3A. COMPLETE THE FOLLOWING SECTION(S) FOR EACH OF THE VETERAN'S INFECTIOUS DISEASE CONDITION(S):

Disease #1: _____

A. Status of disease: ☐ Active ☐ Inactive

Date of cessation of treatment for active disease: _____

If "Inactive," date condition became inactive: _____

B. Does the Veteran have symptoms attributable to disease #1?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the Veteran have residuals attributable to disease #1?

☐ Yes ☐ No

If "Yes," describe: _____

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

Disease #2: _____

A. Status of disease: ☐ Active ☐ Inactive

Date of cessation of treatment for active disease: _____

If "Inactive," date condition became inactive: _____

B. Does the Veteran have symptoms attributable to disease #2?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the Veteran have residuals attributable to disease #2?

☐ Yes ☐ No

If "Yes," describe: _____

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

Disease #3: _____

A. Status of disease: ☐ Active ☐ Inactive

Date of cessation of treatment for active disease: _____

If "Inactive," date condition became inactive: _____

B. Does the Veteran have symptoms attributable to disease #3?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the Veteran have residuals attributable to disease #3?

☐ Yes ☐ No

If "Yes," describe: _____

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

3B. IF THE VETERAN HAS ANY ADDITIONAL INFECTIOUS DISEASE CONDITIONS, LIST AND DESCRIBE BY USING THE ABOVE FORMAT:

SECTION IV - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY OF THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

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

4B. 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 appropriate dermatological DBQ:

4C. COMMENTS, IF ANY:

SECTION V - DIAGNOSTIC TESTING

Note: VA requires diagnostic confirmation for both the initial diagnosis and any relapse or recurrence. Certain infectious diseases require specific testing methods to confirm recurrence of active infection. If testing has been performed and reflects Veteran's current condition, repeat testing is not required. (For VA purposes, relapse is defined as a full return of a disease or the signs and symptoms of a disease after a period of improvement and recurrence refers to another separate disease episode after a full recovery has been attained).

5A. FOR VISCERAL LEISHMANIASIS, MILIARY TUBERCULOSIS OR NONTUBERCULOSIS MYCOBACTERIUM INFECTION, PLEASE STATE IF THE RECURRENCE OF ACTIVE INFECTION IS CONFIRMED BY:

☐ CULTURE
☐ HISTOPATHOLOGY
☐ OTHER DIAGNOSTIC LABORATORY TESTING

Please provide type of test or procedure, date and results (brief summary):

SECTION V - DIAGNOSTIC TESTING

5B. FOR MALARIA, PLEASE STATE IF THE INITIAL DIAGNOSIS OR RELAPSE IS CONFIRMED BY:

- ☐ IDENTIFICATION OF THE MALARIAL PARASITES IN BLOOD SMEARS
- ☐ IDENTIFICATION OF THE MALARIAL PARASITES IN OTHER SPECIFIC DIAGNOSTIC LABORATORY TESTS, SUCH AS ANTIGEN DETECTION, IMMUNOLOGIC (IMMUNOCHROMATOGRAPHIC) TESTS, OR MOLECULAR TESTING SUCH AS POLYMERASE CHAIN REACTION TESTS

Please provide type of test or procedure, date and results (brief summary):

5C. FOR BRUCELLOSIS, PLEASE STATE IF THE INITIAL DIAGNOSIS OR RECURRENCE OF ACTIVE INFECTION IS CONFIRMED BY:

- ☐ CULTURE
- ☐ SEROLOGIC TESTING

Please provide type of test or procedure, date and results (brief summary):

5D. FOR MELIOIDOSIS, PLEASE STATE IF THE INITIAL DIAGNOSIS AND ANY RELAPSE OR CHRONIC ACTIVITY OF INFECTION IS CONFIRMED BY:

- ☐ CULTURE
- ☐ OTHER SPECIFIC DIAGNOSTIC LABORATORY TESTS

Please provide type of test or procedure, date and results (brief summary):

5E. FOR INITIAL DIAGNOSIS, RELAPSE, OR RECURRENCE OF ALL OTHER INFECTIOUS DISEASES, PLEASE STATE THE WAY IN WHICH ACTIVE INFECTION IS CONFIRMED:

Please provide type of test or procedure, date and results (brief summary):

SECTION VI - FUNCTIONAL IMPACT

6A. DOES THE VETERAN'S INFECTIOUS DISEASE CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

If "Yes," describe the impact of each of the Veteran's infectious disease condition(s), providing one or more examples:

SECTION VII - REMARKS

7A. REMARKS (If any):

SECTION VIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

8A. Examiner's signature:

8B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

8C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

8D. Date Signed:

8E. Examiner's phone/fax numbers:

8F. National Provider Identifier (NPI) number:

8G. Medical license number and state:

8H. Examiner's address: