Department of Veterans Affairs

RECTUM AND ANUS CONDITIONS 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/SHE EVER HAD ANY CONDITION OF THE RECTUM OR ANUS?

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

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

☐	Internal or external hemorrhoids	ICD code:		Date of diagnoses:	
☐	Anal/perianal fistula	ICD code:		Date of diagnoses:	
☐	Rectal stricture	ICD code:		Date of diagnoses:	
☐	Impairment of rectal sphincter control	ICD code:		Date of diagnoses:	
☐	Rectal prolapse	ICD code:		Date of diagnoses:	
☐	Pruritus ani	ICD code:		Date of diagnoses:	
☐	Other, specify below:				
	Other diagnoses #1:	ICD code:		Date of diagnoses:	
	Other diagnoses #2:	ICD code:		Date of diagnoses:	

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO RECTUM OR ANUS CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITIONS?

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THE DIAGNOSED CONDITIONS:

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY OF THE DIAGNOSES IN SECTION 1, DIAGNOSIS?

☐ YES ☐ NO IF YES, SPECIFY THE CONDITIONS BELOW AND COMPLETE THE APPROPRIATE SECTIONS.

☐ INTERNAL OR EXTERNAL HEMORRHOIDS

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

- ☐ Mild or moderate
  - If checked, describe:
- ☐ Large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences
- ☐ With persistent bleeding
- ☐ With secondary anemia
  - If checked, provide hemoglobin/hematocrit in Diagnostic Testing Section.
- ☐ With fissures
- ☐ Other, describe:

☐ ANAL/PERIANAL FISTULA

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

- ☐ Slight impairment of sphincter control, without leakage
  - If checked, describe:
- ☐ Leakage necessitates wearing of pad
- ☐ Constant slight leakage
- ☐ Occasional moderate leakage
- ☐ Occasional involuntary bowel movements
- ☐ Extensive leakage
- ☐ Fairly frequent involuntary bowel movements
- ☐ Complete loss of sphincter control
- ☐ Other, describe:

SECTION III - SYMPTOMS OF RECTUM OR ANUS CONDITION(S) *(Continued)*

☐ RECTAL STRICTURE

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

- ☐ Moderate reduction of lumen
- ☐ Great reduction of lumen
- ☐ Moderate constant leakage
- ☐ Extensive leakage
- ☐ Requiring colostomy *(which is present)*
- ☐ Other, describe: _____

☐ IMPAIRMENT OF RECTAL SPHINCTER CONTROL

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

- ☐ Slight impairment of sphincter control, without leakage

  If checked, describe: _____
- ☐ Leakage necessitates wearing of pad
- ☐ Constant slight leakage
- ☐ Occasional moderate leakage
- ☐ Occasional involuntary bowel movements
- ☐ Extensive leakage
- ☐ Fairly frequent involuntary bowel movements
- ☐ Complete loss of sphincter control
- ☐ Other, describe: _____

☐ RECTAL PROLAPSE

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

- ☐ Mild with constant slight or occasional moderate leakage
- ☐ Moderate, persistent or frequently recurring
- ☐ Severe *(or complete)*, persistent
- ☐ Other, describe: _____

☐ PRURITUS ANI

IF CHECKED, INDICATE UNDERLYING CONDITION AND DESCRIBE: _____

(If appropriate complete a questionnaire for each underlying condition, such as VA Form 21-0960F-2, Skin Diseases Disability Benefits Questionnaire)

SECTION IV - EXAM

4. PROVIDE RESULTS OF EXAMINATION OF RECTAL/ANAL AREA *(check all that apply):*

- ☐ No exam performed for this condition; provide reason: _____
- ☐ Normal; no external hemorrhoids, anal fissures or other abnormalities
- ☐ No external hemorrhoids; skin tags only
- ☐ Small or moderate external hemorrhoids
- ☐ Large external hemorrhoids
- ☐ Thrombotic external hemorrhoids
- ☐ Reducible external hemorrhoids
- ☐ Irreducible external hemorrhoids
- ☐ Excessive redundant tissue
- ☐ Anal fissure(s)

  If checked, describe: _____
- ☐ Other, describe: _____

SECTION V - TUMORS AND NEOPLASMS

5A. 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.

5B. Is the neoplasm

◯ Benign

◯ Malignant (if malignant complete the following):

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

SECTION V - TUMORS AND NEOPLASMS *(Continued)*

5C. 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: _____

5D. 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:

5E. 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 VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

6A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, DESCRIBE (*brief summary*):

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

6B. 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 ABOVE?

☐ YES ☐ NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM *(6 square inches)*; OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

☐ YES ☐ NO

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

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: _____ MEASUREMENTS: length _____ cm X width _____ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in Comment Section below. It is not necessary to also complete a Scars DBQ.

6C. COMMENTS, IF ANY:

SECTION VII - DIAGNOSTIC TESTING

NOTE - If imaging studies, diagnostic procedures or laboratory testing have been performed and reflect the veteran's current condition, no further testing is required for this examination report.

7A. 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: _____

7B. 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):*

7C. 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 VIII - FUNCTIONAL IMPACT

8. DOES THE VETERAN'S RECTUM OR ANUS CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

(If "Yes," describe the impact of each of the veteran's rectum or anus conditions, providing one or more examples):

SECTION IX - REMARKS

9. REMARKS *(If any)*

SECTION X - EXAMINER'S CERTIFICATION AND SIGNATURE

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

10A. Examiner's signature:

10B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

10C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

10D. Date Signed:

10E. Examiner's phone/fax numbers:

10F. National Provider Identifier (NPI) number:

10G. Medical license number and state:

10H. Examiner's address:

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

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.