Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
COLD INJURY RESIDUALS 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 ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	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.

IS THIS DBQ BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

☐ YES ☐ NO

If no, how was the examination completed (check all that apply)?

☐ In-person examination
☐ Records reviewed
☐ Other, please specify:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the DBQ and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with a telephone interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with a telephone interview provided sufficient information on which to prepare the DBQ and such an examination would likely provide no additional relevant evidence.

☐ Examination via approved video telehealth

☐ In-person examination

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

☐ Not requested
☐ VA claims file (hard copy paper C-file
☐ VA e-folder (VBMS or Virtual VA)
☐ CPRS
☐ Other (please identify other evidence reviewed):
☐ No records were reviewed

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH ANY COLD INJURY(IES)?

☐ YES ☐ NO

1B. IF YES, ONLY PROVIDE DIAGNOSES THAT PERTIAN TO COLD INJURY(IES).

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 CHRONIC FATIGUE SYNDROME, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY OF THE VETERAN'S COLD INJURY, INCLUDING CIRCUMSTANCES OF ONSET, BODY PARTS AFFECTED, SIGNS AND SYMPTOMS AT TIME OF COLD INJURY, INITIAL TREATMENT AND CURRENT TREATMENT, INCLUDING NON-MEDICAL MEASURES SUCH AS MOVING TO A WARMER CLIMATE, WEARING EXTRA SOCKS, ETC. *(brief summary):*

2B. DOMINANT HAND:

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION III - SIGNS AND SYMPTOMS

3. INDICATE BODY PARTS AFFECTED AND CURRENT SIGNS AND SYMPTOMS FOR EACH AFFECTED PART *(check all that apply)*:

☐ RIGHT HAND

- ☐ NO SIGNS OR SYMPTOMS AT PRESENT TIME
- ☐ ARTHRALGIA OR OTHER PAIN
- ☐ NUMBNESS
- ☐ COLD SENSITIVITY
- ☐ TISSUE LOSS
- ☐ COLOR CHANGES
- ☐ LOCALLY IMPAIRED SENSATION
- ☐ HYPERHIDROSIS
- ☐ NAIL ABNORMALITIES

FOR ALL CHECKED CONDITIONS, DESCRIBE:

☐ LEFT HAND

- ☐ NO SIGNS OR SYMPTOMS AT PRESENT TIME
- ☐ ARTHRALGIA OR OTHER PAIN
- ☐ NUMBNESS
- ☐ COLD SENSITIVITY
- ☐ TISSUE LOSS
- ☐ COLOR CHANGES
- ☐ LOCALLY IMPAIRED SENSATION
- ☐ HYPERHIDROSIS
- ☐ NAIL ABNORMALITIES

FOR ALL CHECKED CONDITIONS, DESCRIBE:

☐ RIGHT FOOT

- ☐ NO SIGNS OR SYMPTOMS AT PRESENT TIME
- ☐ ARTHRALGIA OR OTHER PAIN
- ☐ NUMBNESS
- ☐ COLD SENSITIVITY
- ☐ TISSUE LOSS
- ☐ COLOR CHANGES
- ☐ LOCALLY IMPAIRED SENSATION
- ☐ HYPERHIDROSIS
- ☐ NAIL ABNORMALITIES

FOR ALL CHECKED CONDITIONS, DESCRIBE:

☐ LEFT FOOT

- ☐ NO SIGNS OR SYMPTOMS AT PRESENT TIME
- ☐ ARTHRALGIA OR OTHER PAIN
- ☐ NUMBNESS
- ☐ COLD SENSITIVITY
- ☐ TISSUE LOSS
- ☐ COLOR CHANGES
- ☐ LOCALLY IMPAIRED SENSATION
- ☐ HYPERHIDROSIS
- ☐ NAIL ABNORMALITIES

FOR ALL CHECKED CONDITIONS, DESCRIBE:

☐ RIGHT EAR

- ☐ NO SIGNS OR SYMPTOMS AT PRESENT TIME
- ☐ PAIN
- ☐ NUMBNESS
- ☐ COLD SENSITIVITY
- ☐ TISSUE LOSS
- ☐ COLOR CHANGES
- ☐ LOCALLY IMPAIRED SENSATION
- ☐ HYPERHIDROSIS

FOR ALL CHECKED CONDITIONS, DESCRIBE:

☐ LEFT EAR

- ☐ NO SIGNS OR SYMPTOMS AT PRESENT TIME
- ☐ PAIN
- ☐ NUMBNESS
- ☐ COLD SENSITIVITY
- ☐ TISSUE LOSS
- ☐ COLOR CHANGES
- ☐ LOCALLY IMPAIRED SENSATION
- ☐ HYPERHIDROSIS

FOR ALL CHECKED CONDITIONS, DESCRIBE:

SECTION III - SIGNS AND SYMPTOMS *(Continued)*

☐ NOSE

- ☐ NO SIGNS OR SYMPTOMS AT PRESENT TIME
- ☐ PAIN
- ☐ NUMBNESS
- ☐ COLD SENSITIVITY
- ☐ TISSUE LOSS
- ☐ COLOR CHANGES
- ☐ LOCALLY IMPAIRED SENSATION
- ☐ HYPERHIDROSIS

FOR ALL CHECKED CONDITIONS, DESCRIBE:

☐ OTHER SPECIFY

- ☐ ARTHRALGIA OR OTHER PAIN
- ☐ NUMBNESS
- ☐ COLD SENSITIVITY
- ☐ TISSUE LOSS
- ☐ COLOR CHANGES
- ☐ LOCALLY IMPAIRED SENSATION
- ☐ HYPERHIDROSIS

FOR ALL CHECKED CONDITIONS, DESCRIBE:

NOTE: If there are amputations of fingers or toes, or complications such as squamous cell carcinoma at the site of a cold injury scar, or peripheral neuropathy, and other disabilities that may be the residual effects of cold injury, such as Raynaud's phenomenon, muscle atrophy, etc., also complete appropriate Questionnaire(s).

SECTION IV - DIAGNOSTIC TESTING

THE DIAGNOSES OF OSTEOPOROSIS, SUBARTICULAR PUNCHED OUT LESIONS OR OSTEOARTHRITIS MUST BE CONFIRMED BY X-RAYS. ONCE THESE ABNORMALITIES HAVE BEEN DOCUMENTED, NO FURTHER IMAGING STUDIES ARE INDICATED.

4A. HAVE X-RAYS BEEN PERFORMED?

☐ YES ☐ NO IF YES, PROVIDE DATE: _____

INDICATE BODY PARTS X-RAYED AND RESULTS:

☐ RIGHT HAND

- ☐ NO EVIDENCE OF OSTEOARTHRITIS, OSTEOPOROSIS, OR SUBARTICULAR PUNCHED OUT LESIONS
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ SUBARTICULAR PUNCHED OUT LESIONS

☐ LEFT HAND

- ☐ NO EVIDENCE OF OSTEOARTHRITIS, OSTEOPOROSIS, OR SUBARTICULAR PUNCHED OUT LESIONS
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ SUBARTICULAR PUNCHED OUT LESIONS

☐ RIGHT FOOT

- ☐ NO EVIDENCE OF OSTEOARTHRITIS, OSTEOPOROSIS, OR SUBARTICULAR PUNCHED OUT LESIONS
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ SUBARTICULAR PUNCHED OUT LESIONS

☐ LEFT FOOT

- ☐ NO EVIDENCE OF OSTEOARTHRITIS, OSTEOPOROSIS, OR SUBARTICULAR PUNCHED OUT LESIONS
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ SUBARTICULAR PUNCHED OUT LESIONS

4B. 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 V - ASSISTIVE DEVICES

5A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHOD 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	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutches	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

5B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION VI - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

6. DUE TO COLD INJURY(IES), 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 EXTREMITY(IES) *(check all extremities for which this applies)*:

☐ RIGHT UPPER

☐ LEFT UPPER

☐ RIGHT LOWER

☐ LEFT LOWER

FOR EACH CHECKED EXTREMITY, DESCRIBE LOSS OF EFFECTIVE FUNCTION, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, AND PROVIDE SPECIFIC EXAMPLES *(brief summary):*

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

7A. 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 ABOVE?

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

7B. 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 THESE SCARS PAINFUL AND/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 DISABILITY BENEFITS QUESTIONNAIRE (DBQ)*.

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 the "Remarks" section. It is not necessary to also complete a Scars/Disfigurement DBQ.

7C. COMMENTS, IF ANY:

SECTION VIII - FUNCTIONAL IMPACT

8. DO THE VETERAN'S COLD INJURY RESIDUALS IMPACT ON HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of the Veteran's cold injuries, providing one or more examples):*

SECTION IX - REMARKS

9. REMARKS *(If any):*

SECTION X - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

10A. PHYSICIAN'S SIGNATURE	10B. PHYSICIAN'S PRINTED NAME	10C. DATE SIGNED

10D. PHYSICIAN'S PHONE/FAX NUMBERS	10E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	10F. 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.