



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 THIS 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 QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA 21-2507, C&P EXAMINATION REQUEST?

YES NO

How was the examination completed? (check all that apply)

- In-person examination
- Records reviewed
- Examination via approved video telehealth
- Other, please specify in comments box:

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

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 A GALLBLADDER OR PANCREAS CONDITION?

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

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

- | | | |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Cholecystitis, chronic | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Cholelithiasis, chronic | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Cholangitis, chronic | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Cholecystectomy (gallbladder, removal of) | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Pancreatitis | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Total pancreatectomy | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Partial pancreatectomy | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Gallbladder neoplasm | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Pancreatic neoplasm | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Gallbladder or pancreas injury, with peritoneal adhesions resulting from this injury | ICD Code: _____ | Date of Diagnosis: _____ |
- (If checked, ALSO complete the Peritoneal Adhesions Questionnaire)
- Other gallbladder 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 GALLBLADDER OR PANCREAS CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION (brief summary):

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

YES NO (If "Yes," list only those medications required for the gallbladder or pancreas condition):

SECTION III - GALLBLADDER CONDITIONS: SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY GALLBLADDER CONDITIONS OR RESIDUALS OF TREATMENT FOR GALLBLADDER CONDITIONS?

YES NO

(If "Yes," check all that apply):

- Gallbladder dyspepsia confirmed by X-ray
(If checked, indicate number of episodes per year):
 0 1 2 3 4 or more
- Attacks gallbladder colic
(If checked, indicate number of attacks per year):
 0 1 2 3 4 or more
- Frequent attacks gallbladder colic
- Infrequent attacks (not over two or three a year) of gallbladder colic
 Mild symptoms Moderate symptoms Severe symptoms
- Cholecystectomy post operative residuals:
 Asymptomatic Mild symptoms Severe symptoms
- Jaundice
(If checked, provide bilirubin level in Diagnostic Testing section)
- Other signs or symptoms, describe: _____

SECTION IV - PANCREAS CONDITIONS: SIGNS AND SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SYMPTOMS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

YES NO

(If "Yes," check all that apply):

Abdominal pain, confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies

(If checked, indicate severity and frequency of attacks, check all that apply):

Mild (typical) Moderately Severe Severe (disabling)

(Indicate number of attacks of MILD (TYPICAL) abdominal pain in the past 12 months):

0 1 2 3 4 5 6 7 8 or more

(Indicate number of attacks of MODERATELY SEVERE abdominal pain in the past 12 months):

0 1 2 3 4 5 6 7 8 or more

(Indicate number of attacks of SEVERE (DISABLING) abdominal pain in the past 12 months):

0 1 2 3 4 5 6 7 8 or more

Remissions/pain-free intermissions between attacks

(If checked, indicate characteristics of remissions):

Good pain-free remissions between attacks

Few pain-free intermissions between attacks

Other findings showing continuing pancreatic insufficiency between attacks

Other symptoms, describe: _____

4B. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR FINDINGS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

YES NO

(If "Yes," check all that apply):

Steatorrhea

(If checked, describe frequency and severity): _____

Malabsorption

(If checked, describe frequency and severity): _____

Diarrhea

(If checked, describe frequency and severity): _____

Severe malnutrition

(If checked, describe deficiency (such as beta-carotene, fat-soluble vitamin deficiencies)): _____

Loss of normal body weight

(If checked, provide baseline weight: _____ and current weight: _____).

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

Other, describe: _____

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

5A. 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):

5B. 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.

5C. COMMENTS, IF ANY:

SECTION VI - DIAGNOSTIC TESTING

NOTE: Diagnosis of pancreatitis must be confirmed by appropriate laboratory and clinical studies. If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

6A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES NO

(If "Yes," check all that apply):

- | | | |
|---|-------------|----------------|
| <input type="checkbox"/> EUS (<i>Endoscopic ultrasound</i>) | Date: _____ | Results: _____ |
| <input type="checkbox"/> ERCP (<i>Endoscopic retrograde cholangiopancreatography</i>) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Transhepatic cholangiogram | Date: _____ | Results: _____ |
| <input type="checkbox"/> MRI or MRCP (<i>magnetic resonance cholangiopancreatography</i>) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Gallbladder scan (<i>HIDA scan or cholescintigraphy</i>) | Date: _____ | Results: _____ |
| <input type="checkbox"/> CT | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other, specify: _____ | Date: _____ | Results: _____ |

6B. HAS LABORATORY TESTING BEEN PERFORMED?

YES NO

(If "Yes," check all that apply):

- | | | |
|--|-------------|----------------|
| <input type="checkbox"/> Alkaline phosphatase | Date: _____ | Results: _____ |
| <input type="checkbox"/> Bilirubin | Date: _____ | Results: _____ |
| <input type="checkbox"/> WBC | Date: _____ | Results: _____ |
| <input type="checkbox"/> Amylase | Date: _____ | Results: _____ |
| <input type="checkbox"/> Lipase | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other, specify: _____ | Date: _____ | Results: _____ |

6C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES NO

(If "Yes," provide type of test or procedure, date and results in a brief summary):

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION(S) IMPACT ON HIS OR HER ABILITY TO WORK?

YES NO *(If "Yes," describe the impact of each of the Veteran's gallbladder and/or pancreas conditions, providing one or more examples):*

SECTION VIII - REMARKS

8. REMARKS *(If any)*

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE		9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED
9D. PHYSICIAN'S PHONE AND FAX NUMBER	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9F. 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.

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. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.