Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE

KIDNEY CONDITIONS (NEPHROLOGY) 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 A KIDNEY CONDITION?

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

1B. IF YES, INDICATE DIAGNOSIS *(check all that apply):*

Diagnosis	ICD CODE	DATE OF DIAGNOSIS
☐ Diabetic nephropathy	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Glomerulonephritis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Hydronephrosis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Interstitial nephritis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Kidney transplant	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Nephrosclerosis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Nephrolithiasis (Kidney Stones)	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Renal artery stenosis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Ureterolithiasis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Neoplasm of the kidney	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Cholesterol emboli	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Cystic kidney disease	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Congenital kidney disorder	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Renal cortical necrosis due to Disseminated Intravascular Coagulation	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Renal tubular disorders	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Kidney abscess	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Pyelonephritis, chronic	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ History of acute nephritis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Kidney removal	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Nephritis, chronic	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Atherosclerotic renal disease	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Renal disease, chronic	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Ureter, stricture	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Renal involvement in diabetes mellitus	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Papillary necrosis	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Renal amyloid disease	ICD CODE: ______	DATE OF DIAGNOSIS: ______
☐ Other inherited kidney disorder Specify: ______	ICD CODE: ______	DATE OF DIAGNOSIS: ______

☐ Other kidney condition *(Specify diagnosis, providing only diagnoses that pertain to kidney 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 KIDNEY CONDITION(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including cause, onset and course)* OF THE VETERAN'S KIDNEY CONDITION(S) *(Give a brief summary):*

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

☐ YES ☐ NO If yes, list medications taken for the diagnosed condition: ______

SECTION III - RENAL DYSFUNCTION

3 DOES THE VETERAN HAVE RENAL DYSFUNCTION? *(Evidence of renal dysfunction includes either persistent proteinuria, hematuria or GFR < 60 cc/min/1.73m2)*

☐ YES ☐ NO *(If yes complete the following section:*

3A. DOES THE VETERAN REQUIRE REGULAR DIALYSIS?

☐ YES ☐ NO

SECTION III - RENAL DYSFUNCTION *(Continued)*

3B. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS DUE TO RENAL DYSFUNCTION?

☐ YES ☐ NO

(If yes, check all that apply):

☐ Proteinuria *(albuminuria)*

(If checked, indicate frequency: (check all that apply)

☐ Recurring ☐ Constant ☐ Persistent

☐ Edema *(due to renal dysfunction)*

(If checked, indicate frequency: (check all that apply)

☐ Some ☐ Transient ☐ Slight ☐ Persistent

☐ Anorexia due to renal dysfunction

☐ Weight loss due to renal dysfunction

If checked, provide baseline weight *(average weight for 2-year period preceding onset of disease):* __________ Provide current weight: __________

☐ Generalized poor health due to renal dysfunction

☐ Lethargy due to renal dysfunction

☐ Weakness due to renal dysfunction

☐ Limitation of exertion due to renal dysfunction

☐ Able to perform only sedentary activity, due to persistent edema caused by renal dysfunction

☐ Markedly decreased function of other organ systems, especially the cardiovascular system, caused by renal dysfunction *(If checked, describe)*:

☐ Other *(If checked, describe)*:

3C. DOES THE VETERAN HAVE HYPERTENSION AND/OR HEART DISEASE DUE TO RENAL DYSFUNCTION OR CAUSED BY ANY KIDNEY CONDITION?

☐ YES ☐ NO *(If Yes, also complete Hypertension and/or Heart Disease Questionnaire, as appropriate.)*

3D. Is the renal tubular disorder symptomatic?

☐ YES ☐ NO

3E. Frequent attacks of colic with infection (pyonephrosis)?

☐ YES ☐ NO

If yes, indicate severity (checked, all that apply):

☐ No symptoms or attacks of colic
☐ Occasional attacks of colic
☐ Frequent attacks of colic
☐ Causing voiding dysfunction
☐ Requires catheter drainage
☐ Causing infection (pyonephrosis)
☐ Causing urolithiasis
☐ Causing impaired kidney function
☐ Other, describe:

SECTION IV - UROLITHIASIS

4. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD KIDNEY, URETAL OR BLADDER CALCULI (UROLITHIASIS)?

☐ YES ☐ NO *If yes, complete the following section:*

4A. INDICATE CURRENT/PAST LOCATION OF CALCULI *(Check all that apply)*

☐ KIDNEY ☐ URETER ☐ BLADDER

4B. HAS THE VETERAN HAD TREATMENT FOR RECURRENT STONE FORMATION IN THE KIDNEY, URETER OR BLADDER?

☐ YES ☐ NO

If yes, indicate treatment (Check all that apply):

☐ Diet therapy required

If checked, specify diet and dates of use: ______________________________

☐ Drug therapy required

If checked, list medication and dates of use: ______________________________

☐ Invasive or non-invasive procedures

If checked, indicate average number of times per year invasive or non-invasive procedures were required:

☐ 0 to 1 per year ☐ 2 per year ☐ more than 2 peryear

Date and facility of most recent invasive or non-invasive procedure: ______________________________

SECTION IV - UROLITHIASIS *(continued)*

4C. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS DUE TO UROLITHIASIS?

☐ YES ☐ NO

If yes, indicate severity (Check all that apply):

☐ No symptoms or attacks of colic
☐ Occasional attacks of colic
☐ Frequent attacks of colic
☐ Causing voiding dysfunction

If checked, also complete the Urinary Tract Conditions Questionnaire:

☐ Catheter drainage ☐ Drainage required ☐ Drainage not required
☐ Infections ☐ Infections noted ☐ No infections noted
☐ Causing hydronephrosis
☐ Causing impaired kidney function
☐ Other, describe: ______________________

SECTION V - URINARY TRACT/ KIDNEY INFECTION

5. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT OR KIDNEY INFECTIONS?

☐ YES ☐ NO

If yes, complete the following section:

5A. ETIOLOGY OF RECURRENT URINARY TRACT OR KIDNEY INFECTIONS:

5B. INDICATE ALL TREATMENT MODALITIES USED FOR RECURRENT URINARY TRACT OR KIDNEY INFECTIONS *(check all that apply):*

☐ No treatment

☐ Long-term drug therapy
If checked, list medications used and indicate dates for courses of treatment over the past 12 months:
____

☐ Recurrent symptomatic infection requiring drainage/frequent hospitalization (greater than two times/year)

☐ Hospitalization
If checked, indicate frequency of hospitalization:
☐ 1 or 2 per year ☐ More than 2 per year

☐ Drainage
If checked, indicate dates when drainage was performed over the past 12 months: ______________________

☐ Continuous intensive management required
If checked, indicate types of treatment and medications used over the past 12 months: ______________________

☐ Intermittent intensive management required
If checked, indicate types of treatment and medications used over the past 12 months: ______________________

☐ Other, describe: ______________________

5C. INFECTIONS

☐ Infections noted ☐ No infections noted

SECTION VI - KIDNEY TRANSPLANT OR REMOVAL

6. HAS THE VETERAN HAD A KIDNEY TRANSPLANT OR REMOVAL?

☐ YES ☐ NO

(If yes, complete the following section:)

6A. HAS THE VETERAN HAD A KIDNEY REMOVED?

☐ YES ☐ NO

(If yes, provide reason):

☐ Kidney donation
☐ Due to disease
☐ Due to trauma or injury
☐ Other, describe: ______________________

6B. HAS THE VETERAN HAD A KIDNEY TRANSPLANT?

☐ YES ☐ NO

If yes, date of transplant: ____________

Name of treatment facility, date of admission and date of discharge for transplant:
____

SECTION VI - KIDNEY TRANSPLANT OR REMOVAL *(continued)*

6C. IS THERE NEPHRITIS, INFECTION, OR PATHOLOGY OF THE OTHER KIDNEY?

☐ YES ☐ NO

6D. IS THE REMAINING KIDNEY AFFECTED BY NEPHRITIS, INFECTION, OR OTHER PATHOLOGY?

☐ YES ☐ NO

SECTION VII - TUMORS AND NEOPLASMS

7A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

(If yes, complete the following section:)

7B. IS THE NEOPLASM

☐ BENIGN ☐ MALIGNANT ☐ ACTIVE ☐ IN REMISSION

7C. 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; currently in watchful waiting status

☐ 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: __________

7D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS 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 residual conditions and complications (brief summary)):*

7E. 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 VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

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

☐ YES ☐ NO

IF YES, DESCRIBE (*brief summary*):

8B. 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.

8C. COMMENTS, IF ANY:

SECTION IX - DIAGNOSTIC TESTING

NOTE: If laboratory test results are in the medical record and reflect the Veteran's current renal function, repeat testing is not required. Provide testing completed appropriate to veteran's condition; testing indicated below is not indicated for every kidney condition.

9A. HAS THE VETERAN HAD LABORATORY OR OTHER DIAGNOSTIC STUDIES PERFORMED?

☐ YES ☐ NO

If yes, provide most recent results (if available):

9B. LABORATORY STUDIES

☐ BUN ☐ Abnormal ☐ Normal Date: __________ Result: __________

☐ Creatinine: REFERENCE RANGE FOR "NORMAL" AT THE LABORATORY PROVIDING THESE RESULTS Date: __________ Result: __________
Lower Limit: __________ Upper Limit: __________

☐ EGFR ☐ Abnormal ☐ Normal Date: __________ Result: __________

9C. URINALYSIS

Test			Date	Result
☐ Hyaline casts	☐ Abnormal	☐ Normal	Date: __________	Result: __________
☐ Granular casts	☐ Abnormal	☐ Normal	Date: __________	Result: __________
☐ RBC's/HPF	☐ Abnormal	☐ Normal	Date: __________	Result: __________
☐ Proteinuria *(albumin)*	☐ Abnormal	☐ Normal	Date: __________	Result: __________
☐ Albumin and casts with history of acute nephritis	☐ Abnormal	☐ Normal	Date: __________	Result: __________
☐ Constant albuminuria with some edema	☐ Abnormal	☐ Normal	Date: __________	Result: __________
☐ Spot urine for protein/creatinine ratio	☐ Abnormal	☐ Normal	Date: __________	Result: __________
☐ 24 hour protein *(mg/day)*			Date: __________	Result: __________

9D. SPOT URINE MICROALBUMIN/CREATININE

Date: __________ Result: __________

9E. 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 KIDNEY CONDITION(S), INCLUDING NEOPLASMS, IF ANY, IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *If yes, describe impact of each of the Veteran's kidney conditions, 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.

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.