Department of Veterans Affairs

LOSS OF SENSE OF SMELL AND/OR TASTE 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 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 Comments:

☐ Examination via approved telehealth

☐ Other, please specify in comments box:

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 questionaire 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 ☐ No records were reviewed

☐ VA claims file (hard copy paper C-file)

☐ VA e-folder (VBMS or Virtual VA)

☐ CPRS

☐ Other (please identify other evidence reviewed):

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH LOSS OF SENSE OF SMELL OR TASTE? *(This is the condition the Veteran is claiming or for which an exam has been requested.)*

☐ YES ☐ NO

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

☐ ANOSMIA *(inability to detect any odor)*	ICD Code: _____	Date of diagnosis: _____
☐ HYPOSMIA *(reduced ability to detect any odors)*	ICD Code: _____	Date of diagnosis: _____
☐ AGEUSIA *(complete lack of taste)*	ICD Code: _____	Date of diagnosis: _____
☐ HYPOGEUSIA *(decrease in sense of taste)*	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 COMPLETE LOSS OF SENSE OF SMELL OR TASTE, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S LOSS OF SENSE OF SMELL OR TASTE *(brief summary):*

SECTION III - SYMPTOMS

3A. DOES THE VETERAN CURRENTLY HAVE LOSS OF SENSE OF SMELL?

☐ YES ☐ NO *(If "Yes," indicate severity)*

☐ PARTIAL
☐ COMPLETE

(If "Yes," is there a known anatomical or pathological basis for this condition?)

☐ YES ☐ NO *(If "Yes," describe)*

3B. DOES THE VETERAN CURRENTLY HAVE LOSS OF SENSE OF TASTE *(unable to detect sweet, salty, sour, or bitter tastes)?*

☐ YES ☐ NO *(If "Yes," indicate severity)*

☐ PARTIAL
☐ COMPLETE

(If "Yes," is there a known anatomical or pathological basis for this condition?)

☐ YES ☐ NO *(If "Yes," describe)*

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

4A. 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 IV - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS *(Continued)*

4B. 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.

4C. COMMENTS, IF ANY:

SECTION V - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for a loss of smell and taste examination.

5A. HAVE IMAGING OR LABORATORY STUDIES BEEN PERFORMED?

☐ YES ☐ NO *(If "Yes," check all that apply):*

☐ Magnetic resonance imaging *(MRI)* Date: _____ Results: _____

☐ Computed tomography *(CT)* Date: _____ Results: _____

☐ Other: _____ Date: _____ Results: _____

5B. HAS QUALITATIVE SMELL TESTING BEEN PERFORMED?

☐ YES ☐ NO *(If "Yes,"complete the following):*

Type of test: _____ Date: _____ Results: _____

5C. 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 VI - FUNCTIONAL IMPACT

6. DOES THE VETERAN'S LOSS OF SENSE OF SMELL OR TASTE IMPACT ON HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the Veteran's conditions related to the loss of sense of smell or taste, providing one or more examples):*

SECTION VII - REMARKS

7. REMARKS *(If any):*

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE AND FAX NUMBERS	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. 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.