Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
OSTEOMYELITIS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF CLAIMANT/VETERAN	CLAIMANT/VETERAN'S SOCIAL SECURITY NUMBER	DATE OF EXAMINATION

NOTE TO EXAMINER - 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.

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
- ☐ VA electronic health record
- ☐ Other (please identify other evidence reviewed):
- ☐ No records were reviewed

EVIDENCE COMMENTS:

DOMINANT HAND

☐ Right ☐ Left ☐ Ambidextrous

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN CURRENTLY HAVE OR HAS PREVIOUSLY HAD A DIAGNOSIS OF OSTEOMYELITIS?

☐ Yes ☐ No

1B. IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO OSTEOMYELITIS

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 OSTEOMYELITIS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S OSTEOMYELITIS (BRIEF SUMMARY):

2B. INDICATE LOCATION OF INITIAL INFECTION (CHECK ALL THAT APPLY):

☐ Pelvis
☐ Cervical vertebrae
☐ Thoracolumbar vertebrae
☐ Long bones of upper extremity Side affected: ☐ Right ☐ Left
☐ Long bones of lower extremity Side affected: ☐ Right ☐ Left
☐ Finger(s): ☐ Right digit(s) affected: _____ ☐ Left digit(s) affected: _____
☐ Toe(s): ☐ Right digit(s) affected: _____ ☐ Left digit(s) affected: _____
☐ Other, specify: _____

☐ Extension into joints (If checked, indicate joints affected):

Right: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle Left: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle

☐ Hand joint(s) ☐ Foot joint(s) ☐ Hand joint(s) ☐ Foot joint(s)

☐ Other, specify: _____

2C. HAS THE VETERAN HAD MEDICAL TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING MEDICAL TREATMENT FOR OSTEOMYELITIS?

☐ Yes ☐ No

(If yes, describe treatment): _____

Date treatment started: _____

Date treatment completed or anticipated date of completion: _____

2D. HAS THE VETERAN HAD SURGICAL TREATMENT FOR OSTEOMYELITIS?

☐ Yes ☐ No

(If yes, indicate surgical procedure and date (if multiple procedures, indicate below)):

Procedure #1: _____

Date: _____ Facility: _____

Procedure #2: _____

Date: _____ Facility: _____

If additional surgical procedures, list using above format:

_____

2E. PROVIDE STATUS OF THE VETERAN'S CURRENT OSTEOMYELITIS CONDITION:

☐ Active (acute, subacute, chronic) ☐ Inactive ☐ Resolved ☐ Other, describe: _____

SECTION III - RECURRENT INFECTIONS

3A. HAS THE VETERAN HAD ANY ADDITIONAL EPISODES OR RECURRING INFECTIONS OF OSTEOMYELITIS FOLLOWING THE INITIAL INFECTION?

☐ Yes ☐ No

(If "Yes," indicate number of additional episodes):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

SECTION III - RECURRENT INFECTIONS *(Continued)*

3B. LOCATION OF RECURRENT INFECTIONS (CHECK ALL THAT APPLY):

- ☐ Pelvis
- ☐ Cervical vertebrae
- ☐ Thoracolumbar vertebrae
- ☐ Long bones of upper extremity — Side affected: ☐ Right ☐ Left
- ☐ Long bones of lower extremity — Side affected: ☐ Right ☐ Left
- ☐ Finger(s): ☐ Right digit(s) affected: _____ ☐ Left digit(s) affected: _____
- ☐ Toe(s): ☐ Right digit(s) affected: _____ ☐ Left digit(s) affected: _____
- ☐ Other, specify: _____
- ☐ Extension into joints

  (If checked, indicate joints affected):

  Right: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Hand joint(s) ☐ Foot joint(s)

  Left: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Hand joint(s) ☐ Foot joint(s)
- ☐ Other, specify: _____

3C. DATES OF RECURRENT INFECTION

Indicate dates of recurrences:

Date of recurrence #1: _____ Site of recurrent infection: _____

Date of recurrence #2: _____ Site of recurrent infection: _____

Date of recurrence #3: _____ Site of recurrent infection: _____

If there are additional recurrences, list using above format: _____

SECTION IV - SIGNS, SYMPTOMS AND FINDINGS

4A. DOES THE VETERAN CURRENTLY HAVE ANY SIGNS OR FINDINGS ATTRIBUTABLE TO OSTEOMYELITIS OR TREATMENT FOR OSTEOMYELITIS?

☐ Yes ☐ No (If yes, check all that apply):

- ☐ Involucrum
- ☐ Sequestrum
- ☐ Discharging sinus
- ☐ Amyloidosis secondary to chronic infection
- ☐ Anemia (If checked, provide CBC results in diagnostic testing section)
- ☐ Other constitutional symptoms (If checked, are the constitutional symptoms continuous?) ☐ Yes ☐ No
- ☐ Decreased joint function or range of motion due to osteomyelitis or residuals of treatment (If checked, indicate affected joints and ALSO complete appropriate Questionnaire for each affected joint and/or spinal segment)

  Right: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Single foot joint ☐ Hand joint(s) ☐ Foot joint(s) ☐ Single hand joint

  Left: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Single foot joint ☐ Hand joint(s) ☐ Foot joint(s) ☐ Single hand joint

  ☐ Cervical vertebral joint(s) ☐ Thoracolumbar vertebral joint(s) Specific vertebral joint(s) affected _____

4B. DOES THE VETERAN CURRENTLY HAVE ANY SYMPTOMS ATTRIBUTABLE TO OSTEOMYELITIS OR TREATMENT FOR OSTEOMYELITIS?

☐ Yes ☐ No (If yes, check all that apply):

- ☐ Pain (If checked, describe):
- ☐ Swelling (If checked, describe):
- ☐ Tenderness (If checked, describe):
- ☐ Erythema (If checked, describe):
- ☐ Warmth (If checked, describe):
- ☐ Malaise (If checked, describe):
- ☐ Other symptoms, describe:

SECTION V - AMPUTATION

5A. HAS THE VETERAN HAD AN AMPUTATION DUE TO OSTEOMYELITIS?

☐ Yes ☐ No (If yes, also complete Amputation Questionnaire)

SECTION VI - ASSISTIVE DEVICES

6A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS 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(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other:	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

_____

_____

6B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION.

SECTION VII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

7A. DUE TO THE VETERAN'S OSTEOMYELITIS OR RESIDUALS OF TREATMENTS, 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 extremities for which this applies):

☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary)

Note: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

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

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

☐ Yes ☐ No (If yes, describe (brief summary)):

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

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?

☐ Yes ☐ No

(If yes, also complete appropriate dermatological DBQ).

8C. COMMENTS, IF ANY:

SECTION IX - DIAGNOSTIC TESTING

9A. HAVE IMAGING OR LABORATORY STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ Yes ☐ No (If yes, indicate tests performed, dates and results):

☐ Bone scan	Date of test: _____	Results: _____
☐ X-ray	Date of test: _____	Results: _____
☐ MRI	Date of test: _____	Results: _____
☐ Complete blood count (CBC)	Date of test: _____	Results: _____
☐ C-reactive protein (CRP)	Date of test: _____	Results: _____
☐ Erythrocyte sedimentation rate (ESR)	Date of test: _____	Results: _____
☐ Blood culture	Date of test: _____	Results: _____
☐ Bone biopsy and culture	Date of test: _____	Results: _____
☐ Other, describe:	Date of test: _____	Results: _____

9B. 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

10A. DOES THE VETERAN'S OSTEOMYELITIS IMPACT HIS OR HER ABILITY TO WORK?

☐ Yes ☐ No (If yes, describe the impact of the Veteran's osteomyelitis or residuals of treatment, providing one or more examples):

SECTION XI - REMARKS

11A. REMARKS (If any)

SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

12A. EXAMINER'S SIGNATURE	12B. EXAMINER'S PRINTED NAME	12C. DATE SIGNED

12D. EXAMINER'S PHONE AND FAX NUMBER	12E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	12F. MEDICAL LICENSE NUMBER AND STATE

12G. EXAMINER'S ADDRESS