Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
RECTUM AND ANUS CONDITIONS
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 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/SHE EVER HAD ANY CONDITION OF THE RECTUM OR ANUS?

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

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

☐ Internal or external hemorrhoids ICD code: ________ Date of diagnoses: ________
☐ Anal/perianal fistula ICD code: ________ Date of diagnoses: ________
☐ Rectal stricture ICD code: ________ Date of diagnoses: ________
☐ Impairment of rectal sphincter control ICD code: ________ Date of diagnoses: ________
☐ Rectal prolapse ICD code: ________ Date of diagnoses: ________
☐ Pruritus ani ICD code: ________ Date of diagnoses: ________
☐ Other, specify below:
Other diagnoses #1: ________ ICD code: ________ Date of diagnoses: ________
Other diagnoses #2: ________ ICD code: ________ Date of diagnoses: ________

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO RECTUM OR ANUS CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S RECTUM OR ANUS CONDITIONS *(brief summary):*

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

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THE DIAGNOSED CONDITIONS: ________

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY OF THE DIAGNOSES IN SECTION 1, DIAGNOSIS?

☐ YES ☐ NO IF YES, SPECIFY THE CONDITIONS BELOW AND COMPLETE THE APPROPRIATE SECTIONS.

☐ INTERNAL OR EXTERNAL HEMORRHOIDS

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

☐ Mild or moderate
If checked, describe: ________
☐ Large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences
☐ With persistent bleeding
☐ With secondary anemia
If checked, provide hemoglobin/hematocrit in Diagnostic Testing Section.
☐ With fissures
☐ Other, describe: ________

☐ ANAL/PERIANAL FISTULA

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

☐ Slight impairment of sphincter control, without leakage
If checked, describe: ________
☐ Leakage necessitates wearing of pad
☐ Constant slight leakage
☐ Occasional moderate leakage
☐ Occasional involuntary bowel movements
☐ Extensive leakage
☐ Fairly frequent involuntary bowel movements
☐ Complete loss of sphincter control
☐ Other, describe: ________

SECTION III - SYMPTOMS OF RECTUM OR ANUS CONDITION(S) *(Continued)*

☐ RECTAL STRICTURE

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

- ☐ Moderate reduction of lumen
- ☐ Great reduction of lumen
- ☐ Moderate constant leakage
- ☐ Extensive leakage
- ☐ Requiring colostomy *(which is present)*
- ☐ Other, describe: ____________________

☐ IMPAIRMENT OF RECTAL SPHINCTER CONTROL

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

- ☐ Slight impairment of sphincter control, without leakage
  If checked, describe: ____________________
- ☐ Leakage necessitates wearing of pad
- ☐ Constant slight leakage
- ☐ Occasional moderate leakage
- ☐ Occasional involuntary bowel movements
- ☐ Extensive leakage
- ☐ Fairly frequent involuntary bowel movements
- ☐ Complete loss of sphincter control
- ☐ Other, describe: ____________________

☐ RECTAL PROLAPSE

IF CHECKED, INDICATE SEVERITY *(check all that apply):*

- ☐ Mild with constant slight or occasional moderate leakage
- ☐ Moderate, persistent or frequently recurring
- ☐ Severe *(or complete)*, persistent
- ☐ Other, describe: ____________________

☐ PRURITUS ANI

IF CHECKED, INDICATE UNDERLYING CONDITION AND DESCRIBE: ____________________

(If appropriate complete a questionnaire for each underlying condition, such as VA Form 21-0960F-2, Skin Diseases Disability Benefits Questionnaire)

SECTION IV - EXAM

4. PROVIDE RESULTS OF EXAMINATION OF RECTAL/ANAL AREA *(check all that apply):*

- ☐ No exam performed for this condition; provide reason: ____________________
- ☐ Normal; no external hemorrhoids, anal fissures or other abnormalities
- ☐ No external hemorrhoids; skin tags only
- ☐ Small or moderate external hemorrhoids
- ☐ Large external hemorrhoids
- ☐ Thrombotic external hemorrhoids
- ☐ Reducible external hemorrhoids
- ☐ Irreducible external hemorrhoids
- ☐ Excessive redundant tissue
- ☐ Anal fissure(s)
  If checked, describe: ____________________
- ☐ 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*):

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

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 - If imaging studies, diagnostic procedures or laboratory testing have been performed and reflect the veteran's current condition, no further testing is required for this examination report.

6A. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ CBC *(if anemia due to any intestinal condition is suspected or present)* Date of test: __________

Hemoglobin: __________ Hematocrit: __________ White blood cell count: __________ Platelets: __________

☐ Other, specify: ______________________ Date of test: __________ Results: __________

6B. HAVE IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary):*

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 *(brief summary):*

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S RECTUM OR ANUS CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the veteran's rectum or anus 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, 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.