



**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**

DOES THE VETERAN HAVE OR HAS HE OR SHE EVER HAD SLEEP APNEA?  YES  NO

**NOTE:** The diagnosis of sleep apnea must be confirmed by a sleep study; provide sleep study results in Diagnostic testing section. If other respiratory condition is diagnosed, complete the Respiratory and / or Narcolepsy Questionnaire(s), in lieu of this one.

IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SLEEP APNEA AND CHECK DIAGNOSTIC TYPE:

- OBSTRUCTIVE ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- CENTRAL ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- MIXED, COMPONENTS OF BOTH ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- OTHER SLEEP DISORDER (*specify*): \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO A DIAGNOSIS OF SLEEP APNEA, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S SLEEP DISORDER CONDITION (*brief summary*):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF A SLEEP DISORDER CONDITION?

YES  NO (*If "Yes," list only those medications required for the veteran's sleep disorder condition*):

2C. DOES THE VETERAN REQUIRE THE USE OF A BREATHING ASSISTANCE DEVICE SUCH AS A CONTINUOUS POSITIVE AIRWAY PRESSURE (*CPAP*) MACHINE?

YES  NO

**SECTION III - FINDINGS, SIGNS AND SYMPTOMS**

DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO SLEEP APNEA?

- YES  NO (*If "Yes," check all that apply*)
- Persistent daytime hypersomnolence  Cor pulmonale
  - Carbon dioxide retention  Requires tracheostomy
  - Chronic respiratory failure
  - Other, describe: \_\_\_\_\_

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

4A. 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*):

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?

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:** An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. 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 diagnostic test results are in the medical record and reflect the veteran's current sleep apnea condition, repeat testing is not required.

5A. HAS A SLEEP STUDY BEEN PERFORMED?

YES  NO

(If, "Yes," does the veteran have documented sleep disorder breathing?)

YES  NO

Date of sleep study: \_\_\_\_\_

Name of facility where sleep study performed, if known: \_\_\_\_\_

Results: \_\_\_\_\_

5B. 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 SLEEP APNEA IMPACT HIS OR HER ABILITY TO WORK?

YES  NO (If "Yes," describe impact of the veteran's sleep apnea, 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 NUMBER

8E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

8F. PHYSICIAN'S ADDRESS

**NOTE** - VA may obtain additional medical information, including additional examinations if necessary to complete VA's review of the veteran's application.

**IMPORTANT** - Physician please fax the completed form to \_\_\_\_\_

(VA Regional Office FAX No.)

**NOTE** - A list of VA Regional Office FAX Numbers can be found at [www.benefits.va.gov/disabilityexams](http://www.benefits.va.gov/disabilityexams) or obtained by calling 1-800-827-1000.

**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 [www.reginfo.gov/public/do/PRAMain](http://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. at