

**Department of Veterans Affairs** **PERITONEAL ADHESIONS 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
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**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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

**SECTION I - DIAGNOSIS**

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A PERITONEAL ADHESION?

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

**NOTE:** These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date is determined through record review or reported history.

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO PERITONEAL ADHESIONS:

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 PERITONEAL ADHESIONS, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including cause, onset and course) OF THE VETERAN'S PERITONEAL ADHESIONS (brief summary):

2B. DOES THE VETERAN HAVE A HISTORY OF OPERATIVE, TRAUMATIC OR INFECTIOUS (INTRAABDOMINAL) PROCESS?

YES  NO IF YES, INDICATE ORGAN(S) AFFECTED (check all that apply):

STOMACH  GALL BLADDER  LIVER  SMALL INTESTINES  LARGE INTESTINES  OTHER: \_\_\_\_\_

2C. HAS THE VETERAN HAD SEVERE PERITONITIS, RUPTURED APPENDIX, PERFORATED ULCER OR OPERATION WITH DRAINAGE?

YES  NO

2D. DOES THE VETERAN HAVE A CURRENT DIAGNOSIS OF PERITONEAL ADHESIONS?

YES  NO IF YES, INDICATE ORGAN(S) AFFECTED (check all that apply):

STOMACH  GALL BLADDER  LIVER  SMALL INTESTINES  LARGE INTESTINES  OTHER: \_\_\_\_\_

2E. DOES THE VETERAN HAVE ANY SIGNS AND/OR SYMPTOMS DUE TO PERITONEAL ADHESIONS?

YES  NO IF YES, INDICATE SIGNS AND SYMPTOMS: (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> DELAYED MOTILITY OF BARIUM MEAL (on X-ray) | <input type="checkbox"/> NAUSEA   |
| <input type="checkbox"/> PARTIAL OR COMPLETE BOWEL OBSTRUCTION      | <input type="checkbox"/> VOMITING   |
| <input type="checkbox"/> REFLEX DISTURBANCES                        | <input type="checkbox"/> ABDOMINAL DISTENTION                             |
| <input type="checkbox"/> PAIN                                       | <input type="checkbox"/> CONSTIPATION (perhaps alternating with diarrhea) |

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

YES  NO LIST MEDICATIONS: \_\_\_\_\_

**SECTION III - SEVERITY OF MANIFESTATIONS OF PERITONEAL ADHESIONS**

**NOTE** - Indicate level of severity of signs and/or symptoms, if present: (Check all that apply in each level)

3A. LEVEL IV

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> SEVERE  | <input type="checkbox"/> DEFINITE PARTIAL OBSTRUCTION SHOWN BY X-RAY | <input type="checkbox"/> FREQUENT EPISODES OF SEVERE COLIC DISTENSION | <input type="checkbox"/> FREQUENT EPISODES OF SEVERE NAUSEA | <input type="checkbox"/> FREQUENT EPISODES OF SEVERE VOMITING |
| <input type="checkbox"/> PROLONGED EPISODES OF SEVERE COLIC DISTENSION | <input type="checkbox"/> PROLONGED EPISODES OF SEVERE NAUSEA         | <input type="checkbox"/> PROLONGED EPISODES OF SEVERE VOMITING        |   |   |

3B. LEVEL III

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> MODERATELY SEVERE | <input type="checkbox"/> PARTIAL OBSTRUCTION MANIFESTED BY DELAYED MOTILITY OF BARIUM MEAL | <input type="checkbox"/> LESS FREQUENT EPISODES OF PAIN | <input type="checkbox"/> LESS PROLONGED EPISODES OF PAIN |
|--|--|---|--|

3C. LEVEL II

- |                                   |   |  |  |  |   |
|-----------------------------------|---|--|--|--|---|
| <input type="checkbox"/> MODERATE | <input type="checkbox"/> PULLING PAIN ON ATTEMPTING WORK OR AGGRAVATED BY MOVEMENTS OF THE BODY | <input type="checkbox"/> OCCASIONAL EPISODES OF COLIC PAIN | <input type="checkbox"/> OCCASIONAL EPISODES OF NAUSEA | <input type="checkbox"/> OCCASIONAL EPISODES OF CONSTIPATION (Perhaps alternating with diarrhea) | <input type="checkbox"/> ABDOMINAL DISTENSION |
|-----------------------------------|---|--|--|--|---|

3D. LEVEL I

MILD, DESCRIBE: \_\_\_\_\_

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

4A. 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, ARE ANY OF THE 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 DISABILITY BENEFITS QUESTIONNAIRE.  
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 the Remarks section below. It is not necessary to also complete a Scars DBQ.

4B. 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 V - DIAGNOSTIC TESTING**

5. HAS THE VETERAN HAD LABORATORY OR OTHER DIAGNOSTIC STUDIES PERFORMED AND ARE THE RESULTS AVAILABLE?

- YES  NO (*If "Yes," provide type of test or procedure, date and results - brief summary*):

**SECTION VI - FUNCTIONAL IMPACT**

6. BASED ON YOUR EXAMINATION AND/OR THE VETERAN'S HISTORY, DOES THE VETERAN'S PERITONEAL ADHESION(S) IMPACT HIS OR HER ABILITY TO WORK?

- YES  NO (*If "Yes," describe the impact of each of the veteran's peritoneal adhesions, 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. 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.

**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, 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](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.