OMB Approved No. 2900-0749
Respondent Burden: 15 minutes
Expiration Date: 06/30/2020

Department of Veterans Affairs

HAIRY CELL AND OTHER B-CELL LEUKEMIAS 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 ON REVERSE 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 use the information you provide on this questionnaire to process the veteran's claim. VA reserves the right to confirm the authenticity of ALL DBQ's completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH HAIRY CELL LEUKEMIA OR ANY OTHER B-CELL LEUKEMIA?

☐ YES ☐ NO *(If "No," skip to Item 6, "Remarks")*

NOTE: Provide only diagnoses that pertain to hairy cell or any other B-cell leukemias

1B. DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
1C. DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
1D. DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1E. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO HAIRY CELL AND OTHER B-CELL LEUKEMIAS, LIST USING ABOVE FORMAT

SECTION II - STATUS OF DISEASE

2. STATUS OF DISEASE

☐ ACTIVE ☐ REMISSION

SECTION III - TREATMENT

3. TREATMENT *(Check one)*

☐ VETERAN IS CURRENTLY UNDERGOING TREATMENT FOR THIS LEUKEMIA WITH SURGICAL, RADIATION, IMMUNOTHERAPY, ANTINEOPLASTIC CHEMOTHERAPY AND/OR OTHER THERAPEUTIC PROCEDURES

☐ VETERAN HAS COMPLETED TREATMENT FOR THIS LEUKEMIA - Date of discontinuance of treatment: _____

SECTION IV - COMPLICATIONS OR RESIDUALS OF TREATMENT

4A. DOES THE VETERAN CURRENTLY HAVE ANY COMPLICATIONS OR RESIDUALS OF TREATMENT? ☐ YES ☐ NO

(Check all that apply)

4B. ARE THERE ANY COMPLICATIONS OR RESIDUALS REQUIRING TRANSFUSION OF PLATELETS OR RED CELLS?

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

- ☐ AT LEAST ONCE PER YEAR BUT LESS THAN ONCE EVERY 3 MONTHS
- ☐ AT LEAST ONCE EVERY 3 MONTHS
- ☐ AT LEAST ONCE EVERY 6 WEEKS

4C. ARE THERE ANY COMPLICATIONS OR RESIDUALS CAUSING RECURRING INFECTIONS?

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

- ☐ AT LEAST ONCE PER YEAR BUT LESS THAN ONCE EVERY 3 MONTHS
- ☐ AT LEAST ONCE EVERY 3 MONTHS
- ☐ AT LEAST ONCE EVERY 6 WEEKS

4D. ARE THERE ANY COMPLICATIONS OR RESIDUALS RELATED TO ANEMIA?

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

- ☐ ASYMPTOMATIC ANEMIA
- ☐ REQUIRES CONTINUOUS MEDICATION
- ☐ REQUIRES BONE MARROW TRANSPLANT - Date: _____
- ☐ SYMPTOMATIC ANEMIA *(Check signs and symptoms that apply)*

☐ WEAKNESS	☐ EASY FATIGABILITY	☐ DYSPNEA ON MILD EXERTION
☐ LIGHT-HEADEDNESS	☐ SHORTNESS OF BREATH	☐ SYNCOPE
☐ CARDIOMEGALY	☐ TACHYCARDIA	☐ DYSPNEA AT REST
☐ HIGH OUTPUT CONGESTIVE HEART FAILURE	☐ HEADACHES	☐ OTHER SYMPTOM(S) *(Specify* _____ *)*

IF AVAILABLE, PROVIDE MOST RECENT HEMOGLOBIN LEVEL (gm/100ml): _____ Date _____

IF AVAILABLE, PROVIDE MOST RECENT PLATELET COUNT: _____ Date _____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV - COMPLICATIONS OR RESIDUALS OF TREATMENT (Continued)

4E. IF ANY OTHER RESIDUAL COMPLICATIONS ARE PRESENT PLEASE SPECIFY:

SECTION V - FUNCTIONAL IMPACT AND REMARKS

5. DOES THE VETERAN'S B-CELL LEUKEMIA IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact, providing one or more examples)*

6. REMARKS *(If any)*

SECTION VI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

7A. PHYSICIAN'S SIGNATURE	7B. PHYSICIAN'S PRINTED NAME	7C. DATE SIGNED

7D. PHYSICIAN'S PHONE AND FAX NUMBER	7E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	7F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain additional medical information, including an examination, 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** 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 required to obtain or retain benefits. 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.