OMB Approved No. 2900-0779
Respondent Burden: 30 Minutes
Expiration Date: 01/31/2018

Department of Veterans Affairs

KIDNEY CONDITIONS (NEPHROLOGY) 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. 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 KIDNEY CONDITION?

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

1B. INDICATE DIAGNOSIS *(check all that apply):*

☐ Diabetic nephropathy	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Glomerulonephritis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Hydronephrosis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Interstitial nephritis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Kidney transplant	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Nephrosclerosis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Nephrolithiasis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Renal artery stenosis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Ureterolithiasis	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Neoplasm of the kidney	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Cholesterol emboli	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Cystic kidney disease	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Congenital kidney disorder	ICD CODE: _____	DATE OF DIAGNOSIS: _____
☐ Other inherited kidney disorder	ICD CODE: _____	DATE OF DIAGNOSIS: _____

Specify: _____

☐ Other kidney condition *(Specify diagnosis, providing only diagnoses that pertain to kidney conditions)*

Other diagnosis #1:

_____ ICD CODE: _____ DATE OF DIAGNOSIS: _____

Other diagnosis #2:

_____ ICD CODE: _____ DATE OF DIAGNOSIS: _____

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO KIDNEY CONDITION(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including cause, onset and course)* OF THE VETERAN'S CURRENT KIDNEY CONDITION(S) *(Give a brief summary):*

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

☐ YES ☐ NO List medications taken for the diagnosed condition: _____

SECTION III - RENAL DYSFUNCTION

3A. DOES THE VETERAN HAVE RENAL DYSFUNCTION? *(Evidence of renal dysfunction includes either persistent proteinuria, hematuria or GFR < 60 cc/min/1.73m2)*

☐ YES ☐ NO *(If yes complete questions 3B - 3D)*

3B. DOES THE VETERAN REQUIRE REGULAR DIALYSIS?

☐ YES ☐ NO

SECTION III - RENAL DYSFUNCTION *(Continued)*

3C. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS DUE TO RENAL DYSFUNCTION?

☐ YES ☐ NO

(If yes check all that apply):

☐ Proteinuria *(albuminuria)*

(If checked, indicate frequency: (check all that apply)

☐ Recurring ☐ Constant ☐ Persistent

☐ Edema *(due to renal dysfunction)*

(If checked, indicate frequency: (check all that apply)

☐ Some ☐ Transient ☐ Slight ☐ Persistent

☐ Anorexia *(due to renal dysfunction)*

☐ Weight loss *(due to renal dysfunction)*

If checked, provide baseline weight *(average weight for 2-year period preceding onset of disease):* _____ Provide current weight: _____

☐ Generalized poor health *(due to renal dysfunction)*

☐ Lethargy *(due to renal dysfunction)*

☐ Weakness *(due to renal dysfunction)*

☐ Limitation of exertion *(due to renal dysfunction)*

☐ Able to perform only sedentary activity, due to persistent edema caused by renal dysfunction

☐ Markedly decreased function of other organ systems, especially the cardiovascular system, caused by renal dysfunction *(If checked, describe)*:

☐ Other *(If checked, describe)*:

3D. DOES THE VETERAN HAVE HYPERTENSION AND/OR HEART DISEASE DUE TO RENAL DYSFUNCTION OR CAUSED BY ANY KIDNEY CONDITION?

☐ YES ☐ NO

(If Yes, also complete VA Form 21-0960A-3, Hypertension Disability Benefits Questionnaire and/or VA Form 21-0960A-4, Heart Conditions (Including Ischemic and Non-Ischemic Heart Disease, Arrhythmias, Valvular Disease and Cardiac Surgery) Disability Benefits Questionnaire, as appropriate.))

SECTION IV - UROLITHIASIS

4A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD KIDNEY, URETAL OR BLADDER CALCULI (UROLITHIASIS)?

☐ YES ☐ NO

(If yes, complete questions 4B - 4D)

4B. INDICATE CURRENT/PAST LOCATION OF CALCULI

☐ KIDNEY ☐ URETER ☐ BLADDER

4C. HAS THE VETERAN HAD TREATMENT FOR RECURRENT STONE FORMATION IN THE KIDNEY, URETER OR BLADDER?

☐ YES ☐ NO

(If yes, indicate treatment (Check all that apply)):

☐ Diet therapy

If checked, specify diet and dates of use: _____

☐ Drug therapy

If checked, list medication and dates of use: _____

☐ Invasive or non-invasive procedures

If checked, indicate average number of times per year invasive or non-invasive procedures were required:

☐ 0 to 1/year ☐ 2/year ☐ more than 2/year

Date and facility of most recent invasive or non-invasive procedure: _____

4D. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS DUE TO UROLITHIASIS?

☐ YES ☐ NO

(If yes, indicate severity (Check all that apply)):

☐ No symptoms or attacks of colic

☐ Occasional attacks of colic

☐ Frequent attacks of colic

☐ Causing voiding dysfunction

☐ Requires catheter drainage

☐ Causing infection *(pyonephrosis)*

☐ Causing hydronephrosis

☐ Causing impaired kidney function

☐ Other, describe: _____

SECTION V - INFECTIONS OF THE KIDNEY AND/OR URINARY TRACT

5A. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT OR KIDNEY INFECTIONS?

☐ YES ☐ NO

(If yes, complete questions 5B - 5C)

5B. ETIOLOGY OF RECURRENT URINARY TRACT OR KIDNEY INFECTIONS:

5C. INDICATE ALL TREATMENT MODALITIES USED FOR RECURRENT URINARY TRACT OR KIDNEY INFECTIONS *(check all that apply):*

☐ No treatment

☐ Long-term drug therapy

If checked, list medications used and indicate dates for courses of treatment over the past 12 months:

_____

☐ Hospitalization

If checked, indicate frequency of hospitalization:

☐ 1 or 2 per year ☐ More than 2 per year

☐ Drainage

If checked, indicate dates when drainage was performed over the past 12 months: _____

☐ Continuous intensive management

If checked, indicate types of treatment and medications used over the past 12 months: _____

☐ Intermittent intensive management

If checked, indicate types of treatment and medications used over the past 12 months: _____

☐ Other, describe: _____

SECTION VI - KIDNEY TRANSPLANT OR REMOVAL

6A. HAS THE VETERAN HAD A KIDNEY TRANSPLANT OR REMOVAL?

☐ YES ☐ NO

(If yes, complete questions 6B - 6C)

6B. HAS THE VETERAN HAD A KIDNEY REMOVED?

☐ YES ☐ NO

(If yes, provide reason):

☐ Kidney donation

☐ Due to disease

☐ Due to trauma or injury

☐ Other, describe: _____

6C. HAS THE VETERAN HAD A KIDNEY TRANSPLANT?

☐ YES ☐ NO

If yes, date of transplant: _____

Name of treatment facility, date of admission and date of discharge for transplant:

_____

SECTION VII - TUMORS AND NEOPLASMS

7A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

(If yes, complete questions 7B - 7E)

7B. IS THE NEOPLASM

☐ BENIGN ☐ MALIGNANT

7C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

☐ YES ☐ NO; WATCHFUL WAITING

SECTION VII - TUMORS AND NEOPLASMS *(Continued)*

7C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES? *(Continued)*

If "Yes," indicate type of treatment the Veteran is currently undergoing or has completed *(check all that apply):*

☐ Treatment completed; currently in watchful waiting status

☐ Surgery
If checked, describe: _____
Date(s) of surgery: _____

☐ Radiation therapy
Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Antineoplastic chemotherapy
Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____

☐ Other therapeutic treatment
If checked, describe treatment: _____
Date of completion of treatment or anticipated date of completion: _____

7D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (INCLUDING METASTASES) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

☐ YES ☐ NO *(If yes, list residual conditions and complications (brief summary)):*

7E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS, DESCRIBE USING THE ABOVE FORMAT:

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

8A. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITION OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

(If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than or equal to 39 square cm (6 square inches)?)

☐ YES ☐ NO

(If yes, also complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire.)

8B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS?

☐ YES ☐ NO *(If yes, describe (brief summary)):*

SECTION IX - DIAGNOSTIC TESTING

NOTE: If laboratory test results are in the medical record and reflect the veteran's current renal function, repeat testing is not required. Provide testing completed appropriate to veteran's condition; testing indicated below is not indicated for every kidney condition.

9A. HAS THE VETERAN HAD LABORATORY OR OTHER DIAGNOSTIC STUDIES PERFORMED?

☐ YES ☐ NO

(If yes, provide most recent results (if available)):

9B. LABORATORY STUDIES

☐ BUN Date: _____ Result: _____
☐ Creatinine Date: _____ Result: _____
☐ EGFR Date: _____ Result: _____

SECTION IX - DIAGNOSTIC TESTING *(Continued)*

9C. URINALYSIS

☐ Hyaline casts	Date:	_____	Result:	_____
☐ Granular casts	Date:	_____	Result:	_____
☐ RBC's/HPF	Date:	_____	Result:	_____
☐ Proteinuria *(albumin)*	Date:	_____	Result:	_____
☐ Spot urine for protein/creatinine ratio	Date:	_____	Result:	_____
☐ 24 hour protein *(mg/day)*	Date:	_____	Result:	_____

9D. SPOT URINE MICROALBUMIN/CREATININE

Date: _____ Result: _____

9E. 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

10. DOES THE VETERAN'S KIDNEY CONDITION(S), INCLUDING NEOPLASMS, IF ANY, IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If yes, describe impact of each of the veteran's kidney conditions, providing one or more examples):*

SECTION XI - REMARKS

11. REMARKS

SECTION XII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

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

12D. PHYSICIAN'S PHONE AND FAX NUMBER	12E. PHYSICIAN'S MEDICAL LICENSE NUMBER	12F. 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** 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**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.