Department of Veterans Affairs

PERSIAN GULF AND/OR AFGHANISTAN INFECTIOUS DISEASES (OTHER THAN TUBERCULOSIS) DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran	Patient/Veteran's Social Security Number	Date of examination:

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.

Note - The Veteran 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 may obtain additional medical information, including an examination, if necessary, to complete VA's review of the Veteran's application. VA reserves the right to confirm the authenticity of ALL completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

1A. Does the Veteran currently have or has the Veteran been diagnosed with any of the infectious diseases listed below?

◯ Yes ◯ No

If "Yes," complete item 1B

1B.

☐	Brucellosis	ICD Code:		Date of Diagnosis:
☐	Campylobacter jejuni	ICD Code:		Date of Diagnosis:
☐	Coxiella burnetii (Q fever)	ICD Code:		Date of Diagnosis:
☐	Malaria	ICD Code:		Date of Diagnosis:
☐	Nontyphoid salmonella	ICD Code:		Date of Diagnosis:
☐	Shigella	ICD Code:		Date of Diagnosis:
☐	Visceral leishmaniasis	ICD Code:		Date of Diagnosis:
☐	West Nile virus	ICD Code:		Date of Diagnosis:
☐	Mycobacterium tuberculosis (TB)*	ICD Code:		Date of Diagnosis:

*If mycobacterium tuberculosis is the only diagnosis checked, do not complete the rest of this questionnaire. Instead, complete the Tuberculosis Disability Benefits Questionnaire. If any other disease(s) have been checked along with mycobacterium tuberculosis, complete the Tuberculosis Disability Benefits Questionnaire and ALSO complete this questionnaire for all other non-tuberculosis related diseases checked above.

SECTION II - MEDICAL HISTORY FOR DISEASE #1

2A. Name of disease #1: _____

Describe history (including onset and course) of the Veteran's disease #1:

2B. Status of disease #1: ◯ Active ◯ Inactive/treated and resolved

Date of cessation of treatment for active disease: _____

2C. If inactive, date disease became inactive/resolved: _____

2D. If inactive/resolved, are there residuals due to the disease?

◯ Yes ◯ No

If yes, describe residuals:

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

SECTION III - MEDICAL HISTORY FOR DISEASE #2

3A. Name of disease #2:

Describe history (including onset and course) of the Veteran's disease #2:

3B. Status of disease #2: ◯ Active ◯ Inactive/treated and resolved

Date of cessation of treatment for active disease:

3C. If inactive, date disease became inactive/resolved:

3D. If inactive/resolved, are there residuals due to the disease?

◯ Yes ◯ No

If yes, describe residuals:

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

SECTION IV - MEDICAL HISTORY FOR DISEASE #3

4A. Name of disease #3:

Describe history (including onset and course) of the Veteran's disease #3:

4B. Status of disease #3: ◯ Active ◯ Inactive/treated and resolved

Date of cessation of treatment for active disease: _____

4C. If inactive, date disease became inactive/resolved _____

4D. If inactive/resolved, are there residuals due to the disease?

◯ Yes ◯ No

If yes, describe residuals:

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

SECTION V - ADDITIONAL PERSIAN GULF AND/OR AFGHANISTAN INFECTIOUS DISEASES

5A. If the Veteran has had any additional Persian Gulf and/or Afghanistan infectious diseases, describe using above format:

SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

6A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any of the conditions listed in the diagnosis section?

◯ Yes ◯ No

If yes, describe (brief summary):

6B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?

◯ Yes ◯ No

If yes, also complete appropriate dermatological questionnaire.

6C. Comments, if any:

SECTION VII - DIAGNOSTIC TESTING

Note: VA requires diagnostic confirmation for both the initial diagnosis and any relapse or recurrence. Certain Persian Gulf and/or Afghanistan infectious diseases require specific testing methods to confirm recurrence of active infection. If testing has been performed and reflects Veteran's current condition, repeat testing is not required. (For VA purposes, relapse is defined as a full return of a disease or the signs and symptoms of a disease after a period of improvement and recurrence refers to another separate disease episode after a full recovery has been attained).

7A. For brucellosis, please state if the initial diagnosis or recurrence of active infection is confirmed by:

☐ Culture

☐ Serologic testing

Please provide type of test or procedure, date and results (brief summary):

7B. For malaria, please state if the initial diagnosis or relapse is confirmed by:

☐ Identification of the malarial parasites in blood smears

☐ Identification of the malarial parasites in other specific diagnostic laboratory tests such as antigen detection, immunologic (immunochromatographic) tests or molecular testing such as polymerase chain reaction tests

Please provide type of test or procedure, date and results (brief summary):

7C. For visceral leishmaniasis, please state if the recurrence of active infection is confirmed by:

☐ Culture

☐ Histopathology

☐ Other diagnostic laboratory testing

Please provide type of test or procedure, date and results (brief summary):

7D. For initial diagnosis, relapse, or recurrence of all other Persian Gulf or Afghanistan infectious diseases, please state the way in which active infection is or was confirmed:

Please provide type of test or procedure, date and results (brief summary):

SECTION VIII - FUNCTIONAL IMPACT

8A. Does the Veteran's Persian Gulf and/or Afghanistan infectious disease(s) impact his or her ability to work?

◯ Yes ◯ No

If yes, describe impact of each of the Veteran's Persian Gulf and/or Afghanistan infectious diseases, providing one or more examples:

SECTION IX - REMARKS

9A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION X - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

10A. Examiner's signature:	10B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

10C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	10D. Date Signed:

10E. Examiner's phone/fax numbers:	10F. National Provider Identifier (NPI) number:	10G. Medical license number and state:

10H. Examiner's address: