Department of Veterans Affairs

URINARY TRACT (INCLUDING BLADDER AND URETHRA) CONDITIONS (EXCLUDING MALE REPRODUCTIVE SYSTEM) 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

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. Does the Veteran currently have, or have they ever been diagnosed with, a urinary tract condition of the bladder or urethra? ◯ Yes ◯ No

If yes, complete Item 1B:

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. 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 determined through record review or reported history.

1B. Provide only diagnoses that pertain to urinary tract conditions of the bladder or urethra:

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 urinary tract conditions of the bladder or urethra, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's urinary tract condition - brief summary:

SECTION III - VOIDING DYSFUNCTION

3A. Does the Veteran have a voiding dysfunction? ◯ Yes ◯ No If yes, complete 3B - 3F.

3B. Etiology of voiding dysfunction, if known:

3C. Does the voiding dysfunction cause urine leakage? ◯ Yes ◯ No If yes, indicate severity:

- ◯ Does not require the wearing of absorbent material
- ◯ Requires absorbent material which must be changed less than 2 times per day
- ◯ Requires absorbent material which must be changed 2 to 4 times per day
- ◯ Requires absorbent material which must be changed more than 4 times per day
- ◯ Other, describe:

3D. Does the voiding dysfunction require the use of an appliance? ◯ Yes ◯ No If yes, describe the appliance:

3E. Does the voiding dysfunction cause increased urinary frequency? ◯ Yes ◯ No If yes, check all that apply:

- ◯ Daytime voiding interval less than 1 hour
- ◯ Daytime voiding interval between 1 and 2 hours
- ◯ Daytime voiding interval between 2 and 3 hours
- ◯ Nighttime awakening to void 2 times
- ◯ Nighttime awakening to void 3 to 4 times
- ◯ Nighttime awakening to void 5 or more times

3F. Does the voiding dysfunction cause signs or symptoms of obstructed voiding? ◯ Yes ◯ No If yes, check all that apply:

- ☐ Hesitancy
- ☐ Slow stream
- ☐ Weak stream
- ☐ Decreased force of stream
- ◯ Urinary retention requiring intermittent catheterization
- ◯ Urinary retention requiring continuous catheterization
- ☐ Uroflowmetry peak flow rate less than 10 cc/sec
- ☐ Post void residuals greater than 150 cc

☐ Recurrent urinary tract infections secondary to obstruction

☐ Stricture disease

If selected, indicate frequency of periodic dilatation:

◯ Does not require dilatation

◯ Requires dilatation

◯ 1 to 2 times per year

◯ Every 2 to 3 months

◯ Other, specify: _____

☐ Other Describe: _____

SECTION IV - UROLITHIASIS

4A. Does the Veteran have a history of bladder calculi (cystolithiasis) or urethral calculi (urethrolithiasis)? ◯ Yes ◯ No If yes, complete 4B - 4D.

4B. Indicate location of calculi - check all that apply:

☐ Bladder

☐ Urethra

4C. Has the Veteran had treatment for recurrent stone formation in the bladder or urethra? ◯ Yes ◯ No

If yes, indicate treatment - check all that apply:

◯ Invasive or non-invasive procedures two times or less per year

◯ Invasive or non-invasive procedures more than two times per year

☐ Diet therapy

☐ Drug therapy

4D. Does the Veteran have signs or symptoms due to cystolithiasis or urethrolithiasis? ◯ Yes ◯ No

If yes, indicate type/severity - check all that apply:

☐ Infection

☐ Voiding dysfunction

☐ Impaired kidney function* If selected, also complete the appropriate questionnaire.

◯ Occasional attacks of colic

◯ Frequent attacks of colic

Is catheter drainage required?

◯ Yes

◯ No

*For VA purposes, renal dysfunction includes evidence demonstrating the following for at least 3 consecutive months during the past 12 months: glomerular filtration rate (GFR) of less than 60 mL/min/1.73m2; or GFR from 60 to 89 mL/min/1.73m2 and the presence of at least one of the following: recurrent red blood cell (RBC) casts, white blood cell (WBC) casts, granular casts, structural kidney abnormalities (cystic, obstructive, or glomerular), or increased secretion of protein in the urine (proteinuria). GFR, estimated GFR (eGFR), and creatinine based approximations of GFR will be accepted for evaluation purposes when determined to be appropriate and calculated by a medical professional. Note: If the medical record contains multiple lab tests during this 12 month period, separated by at least 3 months, and there is no evidence to contradict those findings in the interim period, VA will accept that the demonstrated renal dysfunction has persisted for at least 3 consecutive months during the past 12 months.

☐ Other Describe: _____

SECTION V - BLADDER OR URETHRAL INFECTION

5A. Does the Veteran have a history of recurrent, symptomatic bladder or urethral infections? ◯ Yes ◯ No If yes, complete 5B & 5C:

5B. Etiology of bladder or urethral infections, if known: _____

5C. If the Veteran has had recurrent, symptomatic urethral or bladder infections, indicate all treatment modalities that apply:

☐ No treatment

☐ Suppressive drug therapy

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

◯ Lasting 6 months or longer ◯ For less than 6 months

☐ Hospitalization If checked, indicate frequency of hospitalizations: ◯ 1 or 2 per year ◯ More than 2 per year

☐ Drainage by stent or nephrostomy tube

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

☐ Continuous intensive management required.

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

☐ Recurrent symptomatic infection

☐ Other Describe: _____

SECTION VI - OTHER BLADDER OR URETHRAL CONDITIONS

6A. Does the Veteran have any findings, signs, or symptoms attributable to a bladder fistula? ◯ Yes ◯ No

If yes, describe in Comment box below (6J).

6B. Does the Veteran have any findings, signs, or symptoms attributable to diverticulum of the bladder? ◯ Yes ◯ No

If yes, describe in Comment box below (6J).

6C. Does the Veteran have suprapubic cystotomy? ◯ Yes ◯ No If yes, provide name of facility and date of procedure in Comment box below (6J).

6D. Does the Veteran have any findings, signs, or symptoms attributable to a urethral fistula? ◯ Yes ◯ No

If yes, describe in Comment box below (6J).

6E. Does the Veteran have multiple urethroperineal fistulae? ◯ Yes ◯ No If yes, describe in Comment box below (6J).

6F. Does the Veteran have a neurogenic or severely dysfunctional bladder? ◯ Yes ◯ No If yes, describe in Comment box below (6J).

6G. Does the Veteran have a history of bladder injury? ◯ Yes ◯ No If yes, describe in Comment box below (6J).

6H. Has the Veteran had other bladder surgery? ◯ Yes ◯ No If yes, describe in Comment box below (6J).

6I. Is there any renal dysfunction* due to a condition noted in this section? ◯ Yes ◯ No If yes, also complete the appropriate questionnaire.

*For VA purposes, renal dysfunction includes evidence demonstrating the following for at least 3 consecutive months during the past 12 months: glomerular filtration rate (GFR) of less than 60 mL/min/1.73m2; or GFR from 60 to 89 mL/min/1.73m2 and the presence of at least one of the following: recurrent red blood cell (RBC) casts, white blood cell (WBC) casts, granular casts, structural kidney abnormalities (cystic, obstructive, or glomerular), or increased secretion of protein in the urine (proteinuria). GFR, estimated GFR (eGFR), and creatinine based approximations of GFR will be accepted for evaluation purposes when determined to be appropriate and calculated by a medical professional. Note: If the medical record contains multiple lab tests during this 12 month period, separated by at least 3 months, and there is no evidence to contradict those findings in the interim period, VA will accept that the demonstrated renal dysfunction has persisted for at least 3 consecutive months during the past 12 months.

6J. Comments (if any, please identify the question number to which the comment pertains):

SECTION VII - TUMORS AND NEOPLASMS

7A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

◯ Yes ◯ No If yes, complete the following section.

7B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

◯ Primary ◯ Secondary (metastatic) (if secondary, indicate the primary site, if known): _____

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

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

☐ Treatment completed

☐ 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 residuals 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 residuals or complications (brief summary), and also complete the appropriate questionnaire:

7E. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the above format:

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

8A. 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:

8B. Does the Veteran have any scars or other disfigurement of the skin related to any conditions, or to the treatment of any of the conditions, listed in the Diagnosis Section?

◯ Yes ◯ No If yes, also complete the appropriate dermatological questionnaire.

8C. Comments, if any:

SECTION IX - DIAGNOSTIC TESTING

Note: If diagnostic test results are in the medical record and reflect the Veteran's current urinary tract condition, repeat testing is not required.

9A. Has the Veteran had diagnostic testing in conjunction with this exam? ◯ Yes ◯ No

If yes, provide significant findings and/or results (type of test or procedure, date and results) - brief summary:

9B. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, provide type of test or procedure, date and results - brief summary:

SECTION X - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

10A. Does the Veteran's condition of the bladder or urethra impact his or her ability to work?

◯ Yes ◯ No

If yes, describe the impact of each of the Veteran's bladder or urethra condition(s), providing one or more examples:

SECTION XI - REMARKS

11A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XII - 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.

12A. Examiner's signature:	12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	12D. Date Signed:

12E. Examiner's phone/fax numbers:	12F. National Provider Identifier (NPI) number:	12G. Medical license number and state:

12H. Examiner's address: