



**INTESTINAL SURGERY (BOWEL RESECTION, COLOSTOMY, ILIOSTOMY)  
 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.

**SECTION I - DIAGNOSIS**

1A. HAS THE VETERAN HAD INTESTINAL SURGERY?

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

1B. SELECT THE VETERAN'S CONDITION (check all that apply)

<input type="checkbox"/> RESECTION OF THE SMALL INTESTINE	ICD Code: _____	Date of diagnosis: _____	Reason for surgery: _____
<input type="checkbox"/> RESECTION OF THE LARGE INTESTINE	ICD Code: _____	Date of diagnosis: _____	Reason for surgery: _____
<input type="checkbox"/> PERITONEAL ADHESIONS ATTRIBUTABLE TO RESECTION OF THE LARGE OR SMALL INTESTINE (If checked, ALSO complete VA Form 21-0960G-6, Peritoneal Adhesions Disability Benefits Questionnaire)	ICD Code: _____	Date of diagnosis: _____	Reason for surgery: _____
<input type="checkbox"/> PERSISTENT FISTULA	ICD Code: _____	Date of diagnosis: _____	Reason for surgery: _____
<input type="checkbox"/> OTHER INTESTINAL SURGERY (specify)			
OTHER DIAGNOSIS #1:			
_____	ICD Code: _____	Date of diagnosis: _____	Reason for surgery: _____
OTHER DIAGNOSIS #2:			
_____	ICD Code: _____	Date of diagnosis: _____	Reason for surgery: _____

1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO INTESTINAL SURGERY, LIST USING ABOVE FORMAT

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S INTESTINAL SURGERY (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S INTESTINAL CONDITION(S)?

YES  NO (If "Yes," list only those medications required for the intestinal condition(s))

**SECTION III - SIGNS AND SYMPTOMS**

3A. DOES THE VETERAN HAVE ANY SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY INTESTINAL SURGERY?

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

Slight symptoms attributable to resection of large intestine (If checked, describe): \_\_\_\_\_

Moderate symptoms attributable to resection of large intestine (If checked, describe): \_\_\_\_\_

Severe symptoms, objectively supported by examination findings, attributable to resection of large intestine (If checked, describe): \_\_\_\_\_

\_\_\_\_\_

Abdominal pain and/or colic pain (If checked, describe): \_\_\_\_\_

Diarrhea (If checked, describe): \_\_\_\_\_

Alternating diarrhea and constipation (If checked, describe): \_\_\_\_\_

Abdominal distension (If checked, describe): \_\_\_\_\_

Anemia (If checked, provide hemoglobin/hematocrit in Section 9, Diagnostic Testing)

Nausea (If checked, describe): \_\_\_\_\_

Vomiting (If checked, describe): \_\_\_\_\_

Pulling pain on attempting work or aggravated by movements of the body (If checked, describe): \_\_\_\_\_

Other (If checked, describe): \_\_\_\_\_

\_\_\_\_\_

**SECTION IV - WEIGHT LOSS**

4A. DOES THE VETERAN HAVE WEIGHT LOSS OR INABILITY TO GAIN WEIGHT ATTRIBUTABLE TO INTESTINAL SURGERY?

YES  NO (If "Yes," complete Items 4B thru 4D)

4B. PROVIDE VETERAN'S BASELINE WEIGHT AND CURRENT WEIGHT (**NOTE:** For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

Baseline weight: \_\_\_\_\_ Current weight: \_\_\_\_\_

4C. HAS THE VETERAN'S WEIGHT LOSS BEEN SUSTAINED FOR 3 MONTHS OR LONGER?

YES  NO

4D. HAS THE VETERAN BEEN UNABLE TO REGAIN WEIGHT DESPITE APPROPRIATE THERAPY?

YES  NO

**SECTION V - ABSORPTION AND NUTRITION**

5. DOES THE VETERAN HAVE ANY INTERFERENCE WITH ABSORPTION AND NUTRITION ATTRIBUTABLE TO RESECTION OF THE SMALL INTESTINE?

YES  NO  NOT APPLICABLE

(If "Yes," does this cause impairment of health objectively supported by examination findings including definite and/or material weight loss?)

YES  NO

(If "Yes," is impairment of health severe?)

YES  NO

(If "Yes," indicate severity of interference with absorption and nutrition)

Definite  Marked

**SECTION VI - OSTOMY**

6. DID THE VETERAN'S INTESTINAL CONDITION REQUIRE AN ILEOSTOMY OR COLOSTOMY?

YES  NO (If "Yes," describe)

**SECTION VII - FISTULA**

7. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD A PERSISTENT INTESTINAL FISTULA ATTRIBUTABLE TO A SURGICAL INTESTINAL CONDITION?

YES  NO

(If "Yes," does the veteran have fecal discharge attributable to this?)

YES  NO

(If "Yes," indicate severity and frequency of fecal discharge (check all that apply))

Slight

Copious

Infrequent

Frequent

Constant

Other (describe): \_\_\_\_\_

**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 CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I?

YES  NO

(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 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 AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I?

YES  NO (If "Yes," describe (brief summary))

**SECTION IX - DIAGNOSTIC TESTING**

9A. HAS LABORATORY TESTING BEEN PERFORMED?

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

CBC (if anemia due to any intestinal condition is suspected or present)

Date of test: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ Hematocrit: \_\_\_\_\_ White blood cell count: \_\_\_\_\_ Platelets: \_\_\_\_\_

Other \_\_\_\_\_

Date of test: \_\_\_\_\_

Results: \_\_\_\_\_

9B. HAVE IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

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

9C. 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 AND REMARKS**

10. DOES THE VETERAN'S INTESTINAL SURGERY RESIDUALS IMPACT HIS OR HER ABILITY TO WORK?

YES  NO (If "Yes," describe the impact of each of the veteran's intestinal surgery residuals, including any ongoing symptoms of original cause of surgery that may be hard to distinguish from post-surgical residuals,, providing one or more examples)

11. REMARKS (If any)

**SECTION XI - 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 obtain 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.vba.va.gov/disabilityexams](http://www.vba.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 a 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.