



**BREAST CONDITIONS AND DISORDERS
 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. DOES THE VETERAN NOW HAVE OR HAS SHE EVER HAD A DISORDER OF THE BREAST(S)?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO THE BREAST(S):

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 THE BREAST(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S CURRENT BREAST CONDITION (brief summary):

2B. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OF THE BREAST?

YES NO

2C. IS THE NEOPLASM

BENIGN MALIGNANT

2D. IF MALIGNANT, WERE THERE OR ARE THERE CURRENTLY ANY METASTASES?

YES NO

(If "Yes," describe locations): _____

SECTION III - TREATMENT/SURGERY

3A. HAS THE VETERAN COMPLETED ANY TYPE OF TREATMENT OF IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM AND/OR METASTASES?

YES NO

(If "Yes," indicate treatment type(s) (check all that apply)):

Watchful waiting

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 and/or treatment (describe): _____

Date of procedure: _____

Date of completion of treatment or anticipated date of completion: _____

SECTION III - TREATMENT/SURGERY (Continued)

3B. HAS THE VETERAN UNDERGONE BREAST SURGERY?

YES NO

(If "Yes," indicate procedure type and severity (check all that apply)):

- Wide local excision (For VA purposes, wide local excision means removal of a portion of the breast tissue and includes partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy)
 Right Left Both
- Simple (or total) mastectomy (For VA purposes, a simple (or total) mastectomy means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact)
 Right Left Both
- Modified radical mastectomy (For VA purposes, a modified radical mastectomy means removal of the entire breast and axillary lymph nodes, in continuity with the breast, with pectoral muscles are left intact)
 Right Left Both
- Radical mastectomy (For VA purposes, radical mastectomy means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament)
 Right Left Both
- Axillary or sentinel lymph node excision Right Left Both
- Significant alteration of size or form Right Left Both
- Biopsy Right Left Both
- Other: _____ Right Left Both

3C. ARE THERE ANY RESIDUAL CONDITIONS CAUSED BY THE BENIGN OR MALIGNANT NEOPLASM OR ITS TREATMENT (e.g., arm swelling, nerve damage to arm)?

YES NO (If "Yes," also complete the VA Form 21-0960O-1, Tumors and Neoplasm's Disability Benefits Questionnaire)

SECTION IV - OBJECTIVE FINDINGS AND RESIDUALS

4. DID THE SURGERY OR RADIATION TREATMENT RESULT IN THE LOSS OF 25 PERCENT OR MORE TISSUE FROM A SINGLE BREAST OR BOTH BREASTS IN COMBINATION?

YES NO

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

5A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

YES NO

(If "Yes," describe (brief summary)):

5B. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO (If "Yes," also complete the VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

SECTION VI - DIAGNOSTIC TESTING

NOTE - If imaging and/or diagnostic test results are in the medical record and reflect the Veteran's current condition, repeat testing is not required.

6. HAS THE VETERAN HAD IMAGING AND/OR DIAGNOSTIC TESTING AND IF SO, ARE THERE SIGNIFICANT FINDINGS AND/OR RESULTS?

YES NO

(If "Yes," provide type of test or procedure, date and results (brief summary)):

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S BREAST CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe the impact of each of the veteran's breast conditions, providing one or more examples)

SECTION VIII - REMARKS

8. REMARKS (If any)

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE

9B. PHYSICIAN'S PRINTED NAME

9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBER

9E. PHYSICIAN'S MEDICAL LICENSE NUMBER

9F. 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.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, 58/VA21/22/28, 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.