Department of Veterans Affairs

KIDNEY CONDITIONS (NEPHROLOGY) DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:	Claimant/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 questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

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

☐ Veteran/Claimant

☐ 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. List the claimed conditions that pertain to this questionnaire:

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 comments section below. 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.

SECTION I - DIAGNOSIS (continued)

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

☐ The Veteran does not have a current diagnosis associated with any claimed condition listed above. (Explain your findings and reasons in the comments section)

☐	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 (kidney stones)	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:	
☐	Nephrocalcinosis	ICD Code:	Date of diagnosis:	
☐	Renal cortical necrosis due to disseminated intravascular coagulation	ICD Code:	Date of diagnosis:	
☐	Renal tubular disorders	ICD Code:	Date of diagnosis:	
	Specify:			
☐	Kidney abscess	ICD Code:	Date of diagnosis:	
☐	Pyelonephritis, chronic	ICD Code:	Date of diagnosis:	
☐	Kidney removal	ICD Code:	Date of diagnosis:	
☐	Nephritis, chronic	ICD Code:	Date of diagnosis:	
☐	Atherosclerotic renal disease	ICD Code:	Date of diagnosis:	
☐	Ureter, stricture	ICD Code:	Date of diagnosis:	
☐	Renal involvement in diabetes mellitus	ICD Code:	Date of diagnosis:	
☐	Papillary necrosis	ICD Code:	Date of diagnosis:	
☐	Renal amyloid disease	ICD Code:	Date of diagnosis:	
☐	Congenital or 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:

1D. Comments:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including cause, onset and course) of the Veteran's kidney condition(s) (give a brief summary):

2B. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?

☐ Yes ☐ No If yes, list medications taken for the diagnosed condition: _____

2C. 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 Hypertension and/or Heart Disease Questionnaire, as appropriate.

SECTION III - RENAL DYSFUNCTION

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.

3A. Does the Veteran have renal dysfunction?

☐ Yes ☐ No If yes complete the following section:

3B. Does the Veteran require regular dialysis?

☐ Yes ☐ No

3C. Does the Veteran have a cystic, obstructive, or glomerular structural kidney abnormality for at least 3 consecutive months during the past 12 months?

☐ Yes ☐ No

(If yes, check all that apply and discuss test(s)/evidence used to confirm the structural abnormality):

☐ Cystic

☐ Obstructive

☐ Glomerular

Tests/evidence discussion:

3D. Is there a renal tubular disorder?

☐ Yes ☐ No

If yes, is the renal tubular disorder symptomatic?

☐ Yes ☐ No

3E. Does the Veteran have any signs or symptoms of hydronephrosis due to obstruction other than upper urinary tract urolithiasis (for upper urinary tract urolithiasis see question 4E)?

☐ Yes ☐ No

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

☐ Requires catheter drainage ☐ Causing infection (pyonephrosis)

☐ Causing impaired kidney function ☐ Other, describe: _____

3F. Does the Veteran have attacks of renal colic due to obstruction other than upper urinary tract urolithiasis (for upper urinary tract urolithiasis see question 4F)?

☐ Yes ☐ No

If yes, indicate frequency:

☐ Occasional attacks of colic ☐ Frequent attacks of colic

SECTION IV - UROLITHIASIS

4A. Does the Veteran now have or has he/she ever had kidney or ureteral calculi (urolithiasis)?

☐ Yes ☐ No If yes, complete the following section:

4B. Indicate current/past location of calculi (check all that apply):

☐ Kidney ☐ Ureter

4C. Does the stone formation cause stricture of the ureter?

☐ Yes ☐ No

If yes, discuss test(s)/evidence used to confirm ureteral stricture:

4D. Has the Veteran had treatment for recurrent stone formation in the kidney or ureter?

☐ Yes ☐ No

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

☐ Diet therapy required

If checked specify diet and dates of use: _____

☐ Drug therapy required

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 per year ☐ 2 per year ☐ more than 2 per year

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

4E. Does the Veteran have any signs or symptoms due to upper urinary tract urolithiasis?

☐ Yes ☐ No

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

☐ Requiring catheter drainage
☐ Causing infections (pyonephrosis)
☐ Causing hydronephrosis
☐ Causing impaired kidney function
☐ Other, describe: _____

4F. Does the Veteran have attacks of colic due to upper urinary tract urolithiasis?

☐ Yes ☐ No

If yes, indicate frequency:

☐ Occasional attacks of colic ☐ Frequent attacks of colic

SECTION V - URINARY TRACT/ KIDNEY INFECTION

5A. Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?

☐ Yes ☐ No

If yes, complete the following section:

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

☐ Suppressive drug therapy

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

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

☐ Other, describe: _____

SECTION VI - KIDNEY REMOVAL OR TRANSPLANT (INCLUDING ELIGIBILITY)

6A. Has the Veteran had a kidney removed, is eligible for a kidney transplant, or has had a kidney transplant?
Note: For VA disability compensation purposes, eligibility for a kidney transplant means the Veteran's kidney function has declined sufficiently that a transplant is or would be necessary based solely on kidney function. Placement on a transplant list is not required in order to establish eligibility for VA disability compensation purposes.

☐ Yes ☐ No

If yes, complete the following section:

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. Is the Veteran's renal disease course such that it is medically determined that the Veteran warrants transplant consideration?

☐ Yes ☐ No

If yes, provide the date the Veteran's renal function was noted to have declined enough to warrant transplant consideration: _____

6D. Has the Veteran had a kidney transplant?

☐ Yes ☐ No If yes, complete the following:

Date of transplant: _____ Date Veteran became eligible, if known: _____

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

SECTION VI - KIDNEY REMOVAL OR TRANSPLANT (INCLUDING ELIGIBILITY) (continued)

6E. If the Veteran underwent kidney removal, is the remaining kidney affected by nephritis, infection, or other pathology?

☐ Yes ☐ No

6F. If the Veteran underwent a kidney transplant, is there nephritis, infection, or other pathology of the transplanted kidney?

☐ Yes ☐ No

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 or symptoms related to any conditions listed in the diagnosis section above?

☐ 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 conditions listed in the diagnosis section?

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

SECTION IX - DIAGNOSTIC TESTING

Note: If laboratory test results are in the medical record and reflect the Veteran's current renal function has persisted for at least 3 consecutive months during the past 12 months, repeat testing is not required. Therefore, 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. Provide testing completed appropriate to Veteran's condition; testing indicated below is not indicated for every kidney condition.

9A. Are there laboratory or other diagnostic studies in the medical records?

☐ Yes ☐ No

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

9B. Were laboratory or other diagnostic studies performed in conjunction with this examination?

☐ Yes ☐ No

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

9C. Laboratory studies (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.)

GFR

Date: _____ Result: _____

Date: _____ Result: _____

Date: _____ Result: _____

9D. Has the Veteran had albumin/creatinine ratio (ACR) greater than or equal to 30mg/g, RBC casts, WBC casts, or hyaline casts present for at least 3 consecutive months during the past 12 months? ☐ Yes ☐ No

If yes, check all that apply and discuss test(s)/evidence used to confirm their presence to include dates:

☐ RBC casts ☐ WBC casts ☐ Hyaline casts ☐ ACR greater than or equal to 30mg/g

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

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. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

☐ Yes ☐ No

If yes, describe the functional impact of each condition, 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.

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: