



Department of Veterans Affairs

**GALLBLADDER AND PANCREAS CONDITIONS  
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

**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 HE OR SHE EVER BEEN DIAGNOSED WITH A GALLBLADDER OR PANCREAS CONDITION?

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

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

- Chronic cholecystitis ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
- Chronic cholelithiasis ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
- Chronic cholangitis ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
- Cholecystectomy ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
- Pancreatitis ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
- Total or partial pancreatectomy ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
- Gallbladder neoplasm ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
(If checked, ALSO complete the VA Form 21-0960O-1, Tumors and Neoplasms Disability Benefits Questionnaire)
- Pancreatic neoplasm ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
(If checked, ALSO complete the VA Form 21-0960O-1, Tumors and Neoplasms Disability Benefits Questionnaire)
- Gallbladder or pancreas injury, with peritoneal adhesions resulting from this injury ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
(If checked, ALSO complete the VA Form 21-0960G-6, Peritoneal Adhesions Disability Benefits Questionnaire)
- Other gallbladder 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 A GALLBLADDER OR PANCREAS CONDITIONS, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S GALLBLADDER OR PANCREAS CONDITION?

YES  NO (If "Yes," list only those medications required for the gallbladder or pancreas condition):

**SECTION III - GALLBLADDER CONDITIONS: SIGNS AND SYMPTOMS**

3A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY GALLBLADDER CONDITIONS OR RESIDUALS OF TREATMENT FOR GALLBLADDER CONDITIONS?

YES  NO

(If "Yes," check all that apply):

Gallbladder disease-induced dyspepsia (including sphincter of Oddi dysfunction and/or biliary dyskinesia)

(If checked, indicate number of episodes per year):

0  1  2  3  4 or more

Attacks of gallbladder colic

(If checked, indicate number of attacks per year):

0  1  2  3  4 or more

Jaundice

(If checked, provide bilirubin level in Diagnostic testing section)

Other signs or symptoms, describe: \_\_\_\_\_

**SECTION IV - PANCREAS CONDITIONS: SIGNS AND SYMPTOMS**

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SYMPTOMS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

YES  NO

(If "Yes," check all that apply):

Abdominal pain, confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies

(If checked, indicate severity and frequency of attacks (check all that apply)):

Typical  Severe  Disabling

(Indicate number of attacks of TYPICAL abdominal pain in the past 12 months):

0  1  2  3  4  5  6  7 or more

(Indicate number of attacks of SEVERE abdominal pain in the past 12 months):

0  1  2  3  4  5  6  7 or more

(Indicate number of attacks of DISABLING abdominal pain in the past 12 months):

0  1  2  3  4  5  6  7 or more

Remissions/pain-free intermissions between attacks

(If checked, indicate characteristics of remissions):

Good pain-free remissions between attacks

Few pain-free intermissions between attacks

Other symptoms, describe: \_\_\_\_\_

4B. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR FINDINGS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

YES  NO

(If "Yes," check all that apply):

Steatorrhea

(If checked, describe frequency and severity): \_\_\_\_\_

Malabsorption

(If checked, describe frequency and severity): \_\_\_\_\_

Diarrhea

(If checked, describe frequency and severity): \_\_\_\_\_

Severe malnutrition

(If checked, describe severity (such as beta-carotene, fat-soluble vitamin deficiencies)): \_\_\_\_\_

Weight loss

(If checked, provide baseline weight: \_\_\_\_\_ and current weight: \_\_\_\_\_).

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease).

Other, describe: \_\_\_\_\_

**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)):

**SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS (Continued)**

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," are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?)

YES  NO

(If "Yes," also complete a Scars Questionnaire.)

**SECTION VI - DIAGNOSTIC TESTING**

**NOTE:** Diagnosis of pancreatitis must be confirmed by appropriate laboratory and clinical studies. If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

6A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO

(If "Yes," check all that apply):

- |   |             |                |
|---|-------------|----------------|
| <input type="checkbox"/> EUS ( <i>Endoscopic ultrasound</i> )                               | Date: _____ | Results: _____ |
| <input type="checkbox"/> ERCP ( <i>Endoscopic retrograde cholangiopancreatography</i> )     | Date: _____ | Results: _____ |
| <input type="checkbox"/> Transhepatic cholangiogram   | Date: _____ | Results: _____ |
| <input type="checkbox"/> MRI or MRCP ( <i>magnetic resonance cholangiopancreatography</i> ) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Gallbladder scan ( <i>HIDA scan or cholescintigraphy</i> )         | Date: _____ | Results: _____ |
| <input type="checkbox"/> CT   | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other, specify: _____  | Date: _____ | Results: _____ |

6B. HAS LABORATORY TESTING BEEN PERFORMED?

YES  NO

(If "Yes," check all that apply):

- |  |             |                |
|--|-------------|----------------|
| <input type="checkbox"/> Alkaline phosphatase  | Date: _____ | Results: _____ |
| <input type="checkbox"/> Bilirubin             | Date: _____ | Results: _____ |
| <input type="checkbox"/> WBC                   | Date: _____ | Results: _____ |
| <input type="checkbox"/> Amylase               | Date: _____ | Results: _____ |
| <input type="checkbox"/> Lipase                | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other, specify: _____ | Date: _____ | Results: _____ |

6C. 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 VII - FUNCTIONAL IMPACT**

7. DOES THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION(S) IMPACT ON HIS OR HER ABILITY TO WORK?

YES  NO (If "Yes," describe the impact of each of the Veteran's gallbladder and/or pancreas conditions, providing one or more examples):

**SECTION VIII - REMARKS**

8. REMARKS *(If any)*

**SECTION XV - 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](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.