



**Compensation and Pension Record
Interchange (CAPRI)**

**CAPRI Compensation and Pension
Worksheet Module (CPWM)
Templates and AMIE Worksheet
Disability Benefits Questionnaires
(DBQs)**

**Release Notes
Patch: DVBA*2.7*163**

April 2011

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Office of Enterprise Development
Management & Financial Systems

Preface

Purpose of the Release Notes

The Release Notes document describes the new features and functionality of patch DVBA*2.7*163 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs).

The information contained in this document is not intended to replace the CAPRI User Manual. The CAPRI User Manual should be used to obtain detailed information regarding specific functionality.

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1. Purpose

The purpose of this document is to provide a high-level overview of user and technical information of the enhancements specifically designed for Patch DVBA*2.7*163.

Patch DVBA *2.7*163 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs) introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application in support of the new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

2. Overview

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved implementation and modification of the following Disability Benefits Questionnaires:

- **DBQ Kidney Conditions (Nephrology)**
- **DBQ Male Reproductive Systems Conditions**
- **DBQ Hematologic and Lymphatic Conditions, Including Leukemia**
- **DBQ Prostate Cancer**

3. Associated Remedy Tickets & New Service Requests

There are no Remedy tickets or New Service Requests associated with patch DVBA*2.7*163.

4. Defects Fixes

4.1. DBQ Report Word Wrapping Issue

The word-wrapping issues that appeared on report preview and output has been addressed. Please note the following:

- If the users display is set to “Windows XP Style”, the user will initially see the word wrapping issue, so we are instructing the user to click “Preview” prior to clicking “Done” to clear the wrapping issue.
- If the users display is set to “Windows Classic Style” they will “not” experience the word wrapping issues.

Please Note: The word-wrapping issue has only been addressed on DBQs contained in this patch. We will fix previously released DBQs in future patches.

5. Enhancements

This section provides an overview of the modifications and primary functionality that will be delivered in Patch DVBA*2.7*163.

5.1 CAPRI – DBQ Template Additions

This patch includes adding two new CAPRI DBQ Templates that are accessible through the Compensation and Pension Worksheet Module (CPWM) of the CAPRI GUI application.

- **DBQ KIDNEY CONDITIONS (NEPHROLOGY)**
- **DBQ MALE REPRODUCTIVE SYSTEMS CONDITIONS**

5.2 CAPRI – DBQ Template Modifications

This patch includes updates made to the following CAPRI DBQ templates approved by the Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO).

Modifications implemented with this patch include updating the following two DBQs listed below. Each DBQ lists the changes that were made with this patch.

5.2.1. DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA:

5.2.1.1. Section 3. Treatment has two new options (i) and (ii) for Anemia:

b. Does the Veteran have anemia, including anemia caused by treatment for a hematologic or lymphatic condition?
Yes No (if "yes", answer both question 3.b.i and 3.b.ii)

i. Is the anemia caused secondary to treatment of another hematologic or lymphatic condition?

Yes No

If yes, provide the name of the other condition: _____

ii. Is continuous medication required for control of the anemia?

Yes No

If yes, list medication(s): _____

5.2.1.2. Section 3. Treatment has two new options (i) and (ii) for Thrombocytopenia:

c. Does the Veteran have thrombocytopenia, including thrombocytopenia caused by treatment for a hematologic or lymphatic condition?

Yes No (if "yes", answer both question 3.c.i and 3.c.ii)

i. Is the thrombocytopenia caused secondary to treatment of another hematologic or lymphatic condition?

Yes No

If yes, provide the name of the other condition: _____

ii. Is continuous medication required for control of the thrombocytopenia?

Yes No

If yes, list medication(s): _____

5.2.1.3. Section 9. Other pertinent physical findings, complications, conditions signs and/or symptoms has a new option (a) for Scars:

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?

Yes No

If yes, describe (brief summary): _____

b. 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 a Scars Questionnaire for each scar.

5.2.1.4. Section 10. Diagnostic testing has new option (a) for CBC:

If testing has been performed and reflects Veteran's current condition, no further testing is required. Provide most recent CBC, hemoglobin level or platelet count appropriate to the Veteran's condition:

a. CBC: _____ Date: _____

b. Hemoglobin level (gm/100ml): _____ Date: _____

c. Platelet count: _____ Date: _____

d. 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): _____

5.2.2. DBQ PROSTATE CANCER:

5.2.2.1. The header was changed to "Prostate Cancer Disability Benefits Questionnaire"

5.2.2.2. Section 3. Treatment (Surgery) has been changed to contain the following options:

- Surgery
- Prostatectomy
 - Radical prostatectomy
 - Transurethral resection prostatectomy
 - Other (describe):

5.2.2.3. Section 3. Treatment (Antineoplastic chemotherapy)

- Date of most recent treatment has been removed

5.2.2.4. Section 4. Residual conditions and/or complications has been changed to Section 4. Voiding dysfunction and contains the following:

Does the Veteran have a voiding dysfunction?

Yes No

If yes, provide etiology of voiding dysfunction:

If the Veteran has a voiding dysfunction, complete the following questions:

- a. Does the voiding dysfunction cause urine leakage?
 Yes No

Indicate severity (check one):

- 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:

- b. Does the voiding dysfunction require the use of an appliance?
 Yes No

If yes, describe the appliance:

- c. Does the voiding dysfunction cause increased urinary frequency?
 Yes No

If yes, check all that apply:

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

- d. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?
 Yes No

If yes, check all that apply:

- Hesitancy
If checked, is hesitancy marked?
 Yes No
 Slow or weak stream
If checked, is stream markedly slow or weak?
 Yes No
 Decreased force of stream
If checked, is force of stream markedly decreased?
 Yes No
 Stricture disease requiring dilatation 1 to 2 times per year
 Stricture disease requiring periodic dilatation every 2 to 3 months
 Recurrent urinary tract infections secondary to obstruction
 Uroflowmetry peak flow rate less than 10 cc/sec
 Post void residuals greater than 150 cc
 Urinary retention requiring intermittent catheterization
 Urinary retention requiring continuous catheterization
 Other, describe:

5.2.2.5. Section 5. Other pertinent physical findings, complications, conditions, signs and/or symptoms has been changed to Section 5. Urinary tract/kidney infection and contains the following:

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?
 Yes No

If yes, provide etiology:

If the Veteran has had recurrent symptomatic urinary tract or kidney infections, indicate all treatment modalities that apply:

- No treatment
- Long-term drug therapy
 - If checked, list medications used and indicate dates for courses of treatment over the past 12 months:
- Hospitalization
 - If checked, indicate frequency of hospitalization:
 - 1 or 2 per year
 - > 2 per year
- Drainage
 - If checked, indicate dates when drainage performed over past 12 months:
- Continuous intensive management
 - If checked, indicate types of treatment and medications used over past 12 months:
- Intermittent intensive management
 - If checked, indicate types of treatment and medications used over past 12 months:
 - Other, describe:

5.2.2.6. Section 6. Diagnostic testing has been changed to Section 6. Erectile dysfunction and contains the following:

- a. Does the Veteran have erectile dysfunction?
 - Yes No
 - If yes, provide etiology:
- b. If the Veteran has erectile dysfunction, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?
 - Yes No
 - If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable:
- c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?
 - Yes No
 - If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?
 - Yes No

5.2.2.7. Section 7. Functional impact has been changed to Section 7. Retrograde ejaculation and contains the following:

- a. Does the Veteran have retrograde ejaculation?
 - Yes No
 - If yes, provide etiology of the retrograde ejaculation:
- b. If the Veteran has retrograde ejaculation, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?
 - Yes No
 - If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable:

5.2.2.8. Section 8. Remarks, if any has been changed to Section 8. Residual conditions and/or complications and contains the following:

- a. Does the Veteran have any other residual conditions and/or complications due to prostate cancer or treatment for prostate cancer?
 Yes No

If yes, describe:

5.2.2.9. Section 9. Other pertinent physical findings, complications, conditions signs and/or symptoms has been added to the DBQ and contains the following:

- a. 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.

- b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
 Yes No

If yes, describe (brief summary):

5.2.3.0. Section 10. Diagnostic testing has been added to the DBQ and contains the following:

NOTE: If laboratory test results are in the medical record and reflect the Veteran's current condition, repeat testing is not required.

Are there any significant diagnostic test findings and/or results?
 Yes No

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

5.2.3.1. New Section 11. Functional impact, was previously Section 7. Functional impact

5.2.3.2. New Section 12. Remarks, if any was previously Section 8. Remarks, if any

5.3 AMIE–DBQ Worksheet Additions

VBAVACO has approved the following new AMIE –DBQ Worksheets that are accessible through the Veterans Health Information Systems and Technology Architecture (VistA) AMIE software package

- **DBQ KIDNEY CONDITIONS (NEPHROLOGY)**
- **DBQ MALE REPRODUCTIVE SYSTEMS CONDITIONS**

5.4 AMIE–DBQ Worksheet Modifications

VBAVACO has approved modifications for the following AMIE –DBQ Worksheets.

- **DBQ HEMIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA**
- **DBQ PROSTATE CANCER**

6. Disability Benefits Questionnaires (DBQs)

The following section illustrates the content of the new questionnaires included in Patch DVBA*2.7*163.

6.1. Kidney Conditions (Nephrology) Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

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.

1. Diagnosis:

Does the Veteran now have or has he/she ever been diagnosed with a kidney condition?

Yes No

If no, provide rationale (e.g., Veteran has never had any known kidney condition(s)):

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

- | | | |
|-------------------------------------------------|-----------------|--------------------------|
| <input type="checkbox"/> Diabetic nephropathy | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Glomerulonephritis | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Hydronephrosis | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Interstitial nephritis | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Kidney transplant | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Nephrosclerosis | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Nephrolithiasis | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Renal artery stenosis | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Ureterolithiasis | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Neoplasm of the kidney | ICD Code: _____ | Date of Diagnosis: _____ |

- 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: _____

If there are additional diagnoses that pertain to kidney conditions, list using above format: _____

2. Medical history

Describe the history (including cause, onset and course) of the Veteran's kidney condition: _____

3. Renal dysfunction

a. Does the Veteran have renal dysfunction?

Yes No

If yes, does the Veteran require regular dialysis?

Yes No

b. Does the Veteran have any signs or symptoms due to renal dysfunction?

Yes No

If yes, check all that apply:

Proteinuria (albuminuria)

If checked, indicate frequency: (check all that apply)

Recurring Constant Persistent

Edema (due to renal dysfunction)

If checked, indicate frequency: (check all that apply)

Some Transient Slight Persistent

Anorexia (due to renal dysfunction)

Weight loss (due to renal dysfunction)

If checked, provide baseline weight (average weight for 2-year period preceding onset of disease):

_____ Provide current weight: _____

Generalized poor health due to renal dysfunction

Lethargy due to renal dysfunction

Weakness due to renal dysfunction

Limitation of exertion due to renal dysfunction

Able to perform only sedentary activity, due to persistent edema caused by renal dysfunction

Markedly decreased function other organ systems, especially the cardiovascular system, caused by renal dysfunction

If checked, describe: _____

c. 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 the Hypertension and/or Heart Disease Questionnaire as appropriate.

4. Urolithiasis

a. Does the Veteran have kidney, ureteral or bladder calculi?

Yes No

If yes, indicate location (check all that apply)

Kidney Ureter Bladder

If the Veteran has urolithiasis, complete the following:

b. Has the Veteran had treatment for recurrent stone formation in the kidney, ureter or bladder?

Yes No

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

Diet therapy

If checked, specify diet and dates of use: _____

Drug therapy

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 > 2 per year

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

c. Does the Veteran have signs or symptoms due to urolithiasis?

Yes No

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

No symptoms or attacks of colic

Occasional attacks of colic

Frequent attacks of colic

Causing voiding dysfunction

Requires catheter drainage

- Causing infection (pyonephrosis)
- Causing hydronephrosis
- Causing impaired kidney function
- Other, describe: _____

5. Urinary tract/kidney infection

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

- Yes No

If yes, provide etiology: _____

If the Veteran has had recurrent symptomatic urinary tract or kidney infections, indicate all treatment modalities that apply:

- No treatment
- Long-term drug therapy
If checked, list medications used and indicate dates for courses of treatment over the past 12 months: _____
- Hospitalization
If checked, indicate frequency of hospitalization:
 - 1 or 2 per year
 - > 2 per year
- Drainage
If checked, indicate dates when drainage performed over past 12 months: _____
- Continuous intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
- Intermittent intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
- Other, describe: _____

6. Kidney transplant or removal

a. 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: _____

b. Has the Veteran had a kidney transplant?

- Yes No

If yes, date of admission: _____

Date of discharge: _____

7. Tumors and neoplasms

a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?

- Yes No

If yes, complete the following:

b. Is the neoplasm

- Benign Malignant

c. 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; currently in watchful waiting status
- 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: _____

d. Does the Veteran currently have any residual conditions 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 residual conditions and complications (brief summary): _____

e. 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:

8. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. 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.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

- Yes No

If yes, describe (brief summary): _____

9. Diagnostic testing

NOTE: If laboratory test results are in the medical record and reflect the Veteran's current renal function, repeat testing is not required.

a. Has the Veteran had laboratory or other diagnostic studies performed?

- Yes No

If yes, provide most recent results, if available:

b. Laboratory studies

- | | | |
|--------------------------------------|-------------|---------------|
| <input type="checkbox"/> BUN: | Date: _____ | Result: _____ |
| <input type="checkbox"/> Creatinine: | Date: _____ | Result: _____ |
| <input type="checkbox"/> EGFR: | Date: _____ | Result: _____ |

c. Urinalysis:

- | | | |
|-----------------------------------------|-------------|---------------|
| <input type="checkbox"/> Hyaline casts: | Date: _____ | Result: _____ |
|-----------------------------------------|-------------|---------------|

- Granular casts: Date: _____ Result: _____
- RBC's/HPF: Date: _____ Result: _____
- Protein (albumin): Date: _____ Result: _____
- Spot urine for protein/creatinine ratio: Date: _____
Result: _____
- 24 hour protein (albumin): Date: _____ Result: _____

d. Urine microalbumin: Date: _____ Result: _____

e. 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): _____

10. Functional impact

Does the Veteran's kidney condition(s), including neoplasms, if any, impact his or her ability to work?

- Yes No

If yes, describe impact of each of the Veteran's kidney conditions, providing one or more examples: _____

11. Remarks, if any: _____

Physician signature: _____ Date: ____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

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 30 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.

6.2. Male Reproductive Systems Conditions Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

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.

1. Diagnosis:

Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system? Yes No

If no, provide rationale (e.g., Veteran has never had any known male reproductive organ conditions):

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

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------|
| <input type="checkbox"/> Erectile dysfunction | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Penis, deformity (e.g., Peyronie's) | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Testis, atrophy, one or both | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Testis, removal, one or both | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Epididymitis, chronic | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Epididymo-orchitis, chronic | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Prostate injury | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Prostate hypertrophy (BPH) | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Prostatitis, chronic | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Prostate surgical residuals (as addressed in items 3-6) | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Neoplasms of the male reproductive system | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.) | ICD Code: _____ | Date of Diagnosis: _____ |

Other diagnosis #1: _____

ICD code: _____

Date of diagnosis: _____

Other diagnosis #2: _____

ICD code: _____

Date of diagnosis: _____

If there are additional diagnoses that pertain to the male reproductive organ conditions, list using above format:

2. Medical history

a. Describe the history (including onset and course) of the Veteran's male reproductive organ condition(s) (brief summary): _____

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

Yes No List medications: _____

c. Has the Veteran had an orchiectomy?

Yes No

Indicate testicle removed: Right Left Both

Indicate reason for removal:

Undescended

Congenitally underdeveloped

Other: provide reason for removal: _____

3. Voiding dysfunction

Does the Veteran have a voiding dysfunction?

Yes No

If yes, provide etiology of voiding dysfunction: _____

If the Veteran has a voiding dysfunction, complete the following questions:

a. Does the voiding dysfunction cause urine leakage?

Yes No

Indicate severity (check one):

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: _____

b. Does the voiding dysfunction require the use of an appliance?

Yes No

If yes, describe the appliance:

c. Does the voiding dysfunction cause increased urinary frequency?

Yes No

If yes, check all that apply:

Daytime voiding interval between 2 and 3 hours

Daytime voiding interval between 1 and 2 hours

Daytime voiding interval less than 1 hour

Nighttime awakening to void 2 times

Nighttime awakening to void 3 to 4 times

Nighttime awakening to void 5 or more times

d. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?

Yes No

If yes, check all that apply:

Hesitancy

If checked, is hesitancy marked?

Yes No

Slow or weak stream

If checked, is stream markedly slow or weak?

Yes No

Decreased force of stream

If checked, is force of stream markedly decreased?

Yes No

Stricture disease requiring dilatation 1 to 2 times per year

Stricture disease requiring periodic dilatation every 2 to 3 months

Recurrent urinary tract infections secondary to obstruction

Uroflowmetry peak flow rate less than 10 cc/sec

Post void residuals greater than 150 cc

Urinary retention requiring intermittent catheterization

- Urinary retention requiring continuous catheterization
- Other, describe: _____

4. Urinary tract/kidney infection

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

- Yes No

If yes, provide etiology: _____

If the Veteran has had recurrent symptomatic urinary tract or kidney infections, indicate all treatment modalities that apply:

- No treatment
- Long-term drug therapy
If checked, list medications used and indicate dates for courses of treatment over the past 12 months: _____
- Hospitalization
If checked, indicate frequency of hospitalization:
 - 1 or 2 per year
 - >2 per year
- Drainage
If checked, indicate dates when drainage performed over past 12 months: _____
- Continuous intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
- Intermittent intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
- Other, describe: _____

5. Erectile dysfunction

a. Does the Veteran have erectile dysfunction?

- Yes No

If yes, provide etiology: _____

b. If the Veteran has erectile dysfunction, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?

- Yes No

If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable:

c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?

- Yes No

If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?

- Yes No

6. Retrograde ejaculation

a. Does the Veteran have retrograde ejaculation?

- Yes No

If yes, provide etiology of the retrograde ejaculation: _____

b. If the Veteran has retrograde ejaculation, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?

- Yes No

If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable:

7. Male reproductive organ infections

Does the Veteran have a history of chronic epididymitis, epididymo-orchitis or prostatitis?

- Yes No

If yes, indicate all treatment modalities that apply:

- No treatment
- Long-term drug therapy
If checked, list medications used and indicate dates for courses of treatment over the past 12 months: _____
- Hospitalization

If checked, indicate frequency of hospitalization:

- 1 or 2 per year
- > 2 per year
- Continuous intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
- Intermittent intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
- Other, describe: _____

8. Physical exam

a. Penis

- Normal
- Not examined per Veteran's request
- Not examined; penis exam not relevant to condition
- Abnormal

If abnormal, indicate severity:

- Loss/removal of half or more of penis
- Loss/removal of glans penis
- Penis deformity (such as Peyronie's disease)
If checked, describe: _____

b. Testes

- Normal
- Not examined per Veteran's request
- Not examined; testicular exam not relevant to condition
- Abnormal

If abnormal, check all that apply:

Right testicle

- Size 1/3 or less of normal
- Size 1/2 to 1/3 of normal
- Considerably harder than normal
- Considerably softer than normal
- Absent
- Other abnormality,
Describe: _____

Left testicle

- Size 1/3 or less of normal
- Size 1/2 to 1/3 of normal
- Considerably harder than normal
- Considerably softer than normal
- Absent
- Other abnormality,
Describe: _____

c. Epididymis

- Normal
- Not examined per Veteran's request
- Not examined; epididymis exam not relevant to condition
- Abnormal

If abnormal, check all that apply:

Right epididymis

- Tender to palpation
- Other, describe: _____

Left epididymis

- Tender to palpation
- Other, describe: _____

d. Prostate

- Normal
- Not examined per Veteran's request
- Not examined; prostate exam not relevant to condition
- Abnormal

If abnormal, describe: _____

9. Tumors and neoplasms

a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?

- Yes No

If yes, complete the following:

b. Is the neoplasm

- Benign Malignant

c. 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; currently in watchful waiting status
- 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: _____

d. Does the Veteran currently have any residual conditions 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 residual conditions and complications (brief summary): _____

e. 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: _____

10. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. 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.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

Yes No

If yes, describe (brief summary): _____

11. Diagnostic testing

NOTE: If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the Veteran's current condition, provide most recent results; no further studies or testing are required for this examination.

a. Has the Veteran had a testicular biopsy to determine the presence of spermatozoa?

Yes No

If yes, were spermatozoa present?

Yes No

Date of biopsy: _____

b. Have any other imaging studies, diagnostic procedures or laboratory testing been performed and are the results available?

Yes No

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

12. Functional impact

Does the Veteran's male reproductive system condition(s), including neoplasms, if any, impact his ability to work?

Yes No

If yes, describe the impact of each of the Veteran's male reproductive system condition(s), providing one or more examples: _____

13. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

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.

6.3. Hematologic and Lymphatic Conditions, including Leukemia Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

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.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a hematologic and/or lymphatic condition?

Yes No

If no, provide rationale (e.g., Veteran does not currently have any known hematologic or lymphatic condition(s)): _____

If yes, select the Veteran's condition:

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------|
| <input type="checkbox"/> Acute lymphocytic leukemia (ALL) | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Acute myelogenous leukemia (AML) | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic myelogenous leukemia (CML) | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Hodgkin's disease | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Non-Hodgkin's lymphoma | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Anemia | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Thrombocytopenia | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Polycythemia vera | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Sickle cell anemia | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Splenectomy | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Hairy cell or other B-cell leukemia: If checked, complete Hairy cell and other B-cell leukemias Questionnaire. | | |
| <input type="checkbox"/> Other hematologic or lymphatic condition(s): _____ | | |

Other diagnosis #1: _____

ICD code: _____

Date of diagnosis: _____

Other diagnosis #2: _____

ICD code: _____

Date of diagnosis: _____

Other diagnosis #3: _____

ICD code: _____

Date of diagnosis: _____

If there are additional diagnoses that pertain to hematologic or lymphatic condition(s), list using above format: _____

2. Medical history

a. Describe the history (including onset, course and status) of the Veteran's current condition(s) (brief summary): _____

b. Indicate the status of the primary condition:

- Active
- Remission
- Not applicable

3. Treatment

a. Has the Veteran completed any treatment or is the Veteran currently undergoing any treatment for any lymphatic or hematologic condition, including leukemia?

- Yes No; watchful waiting

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

- Treatment completed; currently in watchful waiting status
- Bone marrow transplant

If checked, provide:

Date of hospital admission and location: _____

Date of hospital discharge after transplant: _____

- 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: _____

b. Does the Veteran have anemia, including anemia caused by treatment for a hematologic or lymphatic condition?

- Yes No (if "yes", answer both question 3.b.i and 3.b.ii)

i. Is the anemia caused secondary to treatment of another hematologic or lymphatic condition?

- Yes No

If yes, provide the name of the other condition: _____

ii. Is continuous medication required for control of the anemia?

- Yes No

If yes, list medication(s): _____

c. Does the Veteran have thrombocytopenia, including thrombocytopenia caused by treatment for a hematologic or lymphatic condition?

- Yes No (if "yes", answer both question 3.c.i and 3.c.ii)

i. Is the thrombocytopenia caused secondary to treatment of another hematologic or lymphatic condition?

- Yes No

If yes, provide the name of the other condition: _____

ii. Is continuous medication required for control of the thrombocytopenia?

- Yes No

If yes, list medication(s): _____

4. Conditions, complications and/or residuals

a. Does the Veteran currently have any conditions, complications and/or residuals due to a hematologic or lymphatic disorder or due to treatment for a hematologic or lymphatic disorder?

- Yes No

If yes, check all that apply:

- Weakness
- Easy fatigability
- Light-headedness
- Shortness of breath
- Headaches
- Dyspnea on mild exertion
- Dyspnea at rest
- Tachycardia
- Syncope
- Cardiomegaly
- High output congestive heart failure
- Complications or residuals of treatment requiring transfusion of platelets or red blood cells
 - If checked, indicate frequency:
 - At least once per year but less than once every 3 months
 - At least once every 3 months
 - At least once every 6 weeks

c. Does the Veteran currently have any other conditions, complications and/or residuals of treatment from a hematologic or lymphatic disorder?

Yes No

If yes, describe (brief summary): _____

5. Recurring infections

Does the Veteran currently have any conditions, complications and/or residuals of treatment for a hematologic or lymphatic disorder that result in recurring infections?

Yes No

If yes, indicate frequency of infections:

- Less than once per year
- At least once per year but less than once every 3 months
- At least once every 3 months
- At least once every 6 weeks

6. Thrombocytopenia (primary, idiopathic or immune)

Does the Veteran have thrombocytopenia?

Yes No

If yes, check all that apply:

- Stable platelet count of 100,000 or more
- Stable platelet count between 70,000 and 100,000
- Platelet count between 20,000 and 70,000
- Platelet count of less than 20,000
- With active bleeding
- Requiring treatment with medication
- Requiring treatment with transfusions

7. Polycythemia vera

Does the Veteran have polycythemia vera?

Yes No

If yes, check all that apply:

- Stable, with or without continuous medication
- Requiring phlebotomy
- Requiring myelosuppressant treatment

NOTE: If there are complications due to polycythemia vera such as hypertension, gout, stroke or thrombotic disease, also complete appropriate Questionnaire(s).

8. Sickle cell anemia

Does the Veteran have sickle cell anemia?

Yes No

If yes, check all that apply:

- Asymptomatic
- In remission
- With identifiable organ impairment
- Following repeated hemolytic sickling crises with continuing impairment of health
- Painful crises several times a year
- Repeated painful crises, occurring in skin, joints, bones or any major organs
- With anemia, thrombosis and infarction
- Symptoms preclude other than light manual labor
- Symptoms preclude even light manual labor

9. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?

Yes No

If yes, describe (brief summary): _____

b. 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 a Scars Questionnaire for each scar.

10. Diagnostic testing

If testing has been performed and reflects Veteran's current condition, no further testing is required.

Provide most recent CBC, hemoglobin level or platelet count appropriate to the Veteran's condition:

a. CBC: _____ Date: _____

b. Hemoglobin level (gm/100ml): _____ Date: _____

c. Platelet count: _____ Date: _____

d. 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): _____

11. Functional impact

Does the Veteran's hematologic and/or lymphatic condition(s) impact his or her ability to work?

Yes No

If yes, describe impact of each of the Veteran's hematologic and/or lymphatic conditions, providing one or more examples: _____

12. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

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6.4. Prostate Cancer Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

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.

1. Diagnosis

Does the Veteran now have or has he ever been diagnosed with prostate cancer?

Yes No

If no, provide rationale (e.g. Veteran has never had prostate cancer): _____

If yes, provide only diagnoses that pertain to prostate cancer.

Diagnosis #1: _____

ICD code: _____

Date of diagnosis: _____

Diagnosis #2: _____

ICD code: _____

Date of diagnosis: _____

Diagnosis #3: _____

ICD code: _____

Date of diagnosis: _____

If there are additional diagnoses that pertain to prostate cancer, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's prostate cancer condition (brief summary): _____

b. Indicate status of disease:

Active

Remission

3. Treatment

Has the Veteran completed any treatment for prostate cancer or is the Veteran currently undergoing any treatment for prostate cancer?

Yes No; watchful waiting

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

Treatment completed; currently in watchful waiting status

Surgery

Prostatectomy

Radical prostatectomy

Transurethral resection prostatectomy

Other (describe) _____

Other surgical procedure (describe): _____

Date of surgery: _____

Radiation therapy

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

- Brachytherapy
Date of treatment: _____
- Antineoplastic chemotherapy
Date of completion of treatment or anticipated date of completion: _____
- Androgen deprivation therapy (hormonal therapy)
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: _____

4. Voiding dysfunction

Does the Veteran have a voiding dysfunction?

- Yes No

If yes, provide etiology of voiding dysfunction: _____

If the Veteran has a voiding dysfunction, complete the following questions:

a. Does the voiding dysfunction cause urine leakage?

- Yes No

Indicate severity (check one):

- 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: _____

b. Does the voiding dysfunction require the use of an appliance?

- Yes No

If yes, describe the appliance:

c. Does the voiding dysfunction cause increased urinary frequency?

- Yes No

If yes, check all that apply:

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

d. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?

- Yes No

If yes, check all that apply:

- Hesitancy
If checked, is hesitancy marked?
 Yes No
- Slow or weak stream
If checked, is stream markedly slow or weak?
 Yes No
- Decreased force of stream
If checked, is force of stream markedly decreased?
 Yes No
- Stricture disease requiring dilatation 1 to 2 times per year
- Stricture disease requiring periodic dilatation every 2 to 3 months
- Recurrent urinary tract infections secondary to obstruction
- Uroflowmetry peak flow rate less than 10 cc/sec

- Post void residuals greater than 150 cc
- Urinary retention requiring intermittent catheterization
- Urinary retention requiring continuous catheterization
- Other, describe: _____

5. Urinary tract/kidney infection

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

- Yes No

If yes, provide etiology: _____

If the Veteran has had recurrent symptomatic urinary tract or kidney infections, indicate all treatment modalities that apply:

- No treatment
- Long-term drug therapy
If checked, list medications used and indicate dates for courses of treatment over the past 12 months: _____
- Hospitalization
If checked, indicate frequency of hospitalization:
 1 or 2 per year
 > 2 per year
- Drainage
If checked, indicate dates when drainage performed over past 12 months: _____
- Continuous intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
- Intermittent intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
- Other, describe: _____

6. Erectile dysfunction

a. Does the Veteran have erectile dysfunction?

- Yes No

If yes, provide etiology: _____

b. If the Veteran has erectile dysfunction, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?

- Yes No

If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable:

c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?

- Yes No

If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?

- Yes No

7. Retrograde ejaculation

a. Does the Veteran have retrograde ejaculation?

- Yes No

If yes, provide etiology of the retrograde ejaculation: _____

b. If the Veteran has retrograde ejaculation, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?

- Yes No

If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable:

8. Residual conditions and/or complications

a. Does the Veteran have any other residual conditions and/or complications due to prostate cancer or treatment for prostate cancer?

Yes No

If yes, describe: _____

9. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. 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.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

Yes No

If yes, describe (brief summary): _____

10. Diagnostic testing

NOTE: If laboratory test results are in the medical record and reflect the Veteran's current condition, repeat testing is not required.

Are there any significant diagnostic test findings and/or results?

Yes No

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

11. Functional impact

Does the Veteran's prostate cancer impact his ability to work?

Yes No

If yes, describe the impact of the Veteran's prostate cancer, providing one or more examples:

12. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

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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.

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7. Software and Documentation Retrieval

7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch Module (NPM). The KIDS build for this patch is DVBA*2.7*163.

7.2 User Documentation

The user documentation for this patch may be retrieved directly using FTP. The preferred method is to FTP the files from:

download.vista.med.va.gov

This transmits the files from the first available FTP server. Sites may also elect to retrieve software directly from a specific server as follows:

OI&T Field Office	FTP Address	Directory
Albany	ftp.fo-albany.med.va.gov	[anonymous.software]
Hines	ftp.fo-hines.med.va.gov	[anonymous.software]
Salt Lake City	ftp.fo-slc.med.va.gov	[anonymous.software]

7.3 Related Documents

The following related documents are available for download from the VistA Documentation Library (VDL): <http://www.va.gov/vdl/application.asp?appid=133>

File Name	Format	Description
DVBA_27_P163_RN.PDF	Binary	Release Notes
DVBA_27_P163_DBQ_HEMICANDLYMPHATIC_WF.DOC	Binary	Workflow doc
DVBA_27_P163_DBQ_KIDNEYCONDITIONS_WF.DOC	Binary	Workflow doc
DVBA_27_P163_DBQ_MALEREPRODUCTIVE_WF.DOC	Binary	Workflow doc
DVBA_27_P163_DBQ_PROSTATECANCER_WF.DOC	Binary	Workflow doc

The VistA Documentation Library (VDL) web site will also contain the 'DVBA*2.7*163 Release Notes. This web site is usually updated within 1-3 days of the patch release date.