Compensation and Pension Record Interchange (CAPRI)

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

Release Notes

Patch: DVBA*2.7*161

March 2011

Department of Veterans Affairs
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*161 (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. Overview

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved implementation of new Disability Benefit Questionnaires:

- Eating Disorders Disability Benefits Questionnaire
- Hematologic And Lymphatic Conditions, Including Leukemia Disability Benefits Questionnaire
- Initial PTSD Disability Benefits Questionnaire
- Mental Disorders (Other Than PTSD And Eating Disorders) Disability Benefits Questionnaire
- Prostate Cancer Disability Benefits Questionnaire
- Review PTSD Disability Benefits Questionnaire

This document provides a high-level overview of Patch DVBA*2.7*161 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQS) that introduces file updates to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application in support of these new Compensation and Pension (C&P) Disability Benefit Questionnaires (DBQs).

1.1 CAPRI - DBQ Template Additions

Patch DVBA*2.7*161 provides the following new templates listed below that are accessible through the Compensation & Pension Worksheet Module (CPWM) of the CAPRI GUI.

- DBQ EATING DISORDERS
- DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA
- DBQ INITIAL PTSD
- DBQ MENTAL DISORDERS (OTHER THAN PTSD AND EATING DISORDERS)
- DBQ PROSTATE CANCER
- DBQ REVIEW PTSD

1.2 CAPRI- DBQ Template Modification

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved the following updates to the CAPRI Disability Benefit Questionnaire templates.

- DBQ ISCHEMIC HEART DISEASE

The examiner's note beginning with "NOTE: IHD includes, but is not limited to ...” has been moved to appear immediately following the "Diagnosis" label.

1.3 AMIE- DBQ Worksheet Additions

This patch implements the following new AMIE C&P Disability Benefit Questionnaire worksheets, which are accessible through the Veterans Health Information Systems and Technology Architecture (VistA) AMIE software package:
- DBQ EATING DISORDERS
- DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA
- DBQ INITIAL PTSD
- DBQ MENTAL DISORDERS (OTHER THAN PTSD AND EATING DISORDERS)
- DBQ PROSTATE CANCER
- DBQ REVIEW PTSD

1.4 AMIE- DBQ Worksheet Modification

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved the following Automated Medical Information Exchange C&P Questionnaire worksheet updates.

- DBQ ISCHEMIC HEART DISEASE

The examiner's note beginning with "NOTE: IHD includes, but is not limited to ..." has been moved to appear immediately following the "Diagnosis" label.

1.5 CAPRI-DBQ Template Defects

There are no CAPRI Template defects being addressed with this patch.

1.6 AMIE – DBQ Worksheet Defects

There are no AMIE Worksheets defects being addressed with this patch.

2. Associated Remedy Tickets, Defects & New Service Requests

There are no Remedy tickets associated with this patch.
3. USER Release Notes

New Features, Functions, and Enhancements

This section contains the changes and primary functionality delivered with patch DVBA*2.7*161. This patch provides the user access to new CAPRI templates and AMIE worksheets (detailed in section 5).

4. Template Views

Templates will not contain the SSN field or Physician Information fields; these are only contained on the AMIE worksheets. In addition a note stating the following will appear at the bottom of each page of the template.

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
5. Disability Benefits Questionnaires

The following section describes the content of the seven new questionnaires.

5.1 Eating Disorders 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.

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the VA Suicide Prevention Hotline at 1-800-273-TALK. Stay on the Hotline until help can link the Veteran to emergency care.

NOTE: In order to conduct an initial examination for eating disorders, the examiner must meet one of the following criteria: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

In order to conduct a REVIEW examination for eating disorders, the examiner must meet one of the criteria from above, OR be a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

1. Diagnosis
Does the Veteran now have or has he/she ever been diagnosed with an eating disorder(s)?
☐ Yes ☐ No

If no, provide rationale (e.g., Veteran does not currently have any diagnosed eating disorders):
__________________________________________

If yes, check all diagnoses that apply:

☐ Bulimia
   Date of diagnosis: ________________
   ICD code: __________
   Name of diagnosing facility or clinician: ________________

☐ Anorexia
   Date of diagnosis: ________________
ICD code: __________
Name of diagnosing facility or clinician: __________________

☐ Eating disorder not otherwise specified
Date of diagnosis: _______________
ICD code: _______________
Name of diagnosing facility or clinician: __________________

2. Medical history
Describe the history (including onset and course) of the Veteran’s eating disorder (brief summary):

_______________________________________

3. Findings
NOTE: For VA purposes, an incapacitating episode is defined as a period during which bedrest and treatment by a physician are required.

☐ Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes
☐ Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year
☐ Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year
☐ Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year
☐ Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding

4. Other symptoms
Does the Veteran have any other symptoms attributable to an eating disorder?
☐ Yes  ☐ No
If yes, describe: ___________________________________________________

5. Functional impact
Does the Veteran’s eating disorder(s) impact his or her ability to work?
☐ Yes  ☐ No
If yes, describe impact, providing one or more examples:

___________________________________________________________

6. Remarks, if any

Psychiatrist/Psychologist/examiner signature & title: _________________________ Date: ____________
Psychiatrist/Psychologist/examiner printed name: _________________________________ Phone: _________
License #: ______________ Psychiatrist/Psychologist/examiner address: _______________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
5.2 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:

☐ Acute lymphocytic leukemia (ALL)    ICD code: ________    Date of diagnosis: _____________
☐ Acute myelogenous leukemia (AML)    ICD code: ________    Date of diagnosis: _____________
☐ Chronic myelogenous leukemia (CML)    ICD code: ________    Date of diagnosis: _____________
☐ Hodgkin’s disease    ICD code: ________    Date of diagnosis: _____________
☐ Non-Hodgkin’s lymphoma    ICD code: ________    Date of diagnosis: _____________
☐ Anemia    ICD code: ________    Date of diagnosis: _____________
☐ Thrombocytopenia    ICD code: ________    Date of diagnosis: _____________
☐ Polycythemia vera    ICD code: ________    Date of diagnosis: _____________
☐ Sickle cell anemia    ICD code: ________    Date of diagnosis: _____________
☐ Splenectomy    ICD code: ________    Date of diagnosis: ____________
☐ Hairy cell and other B-cell leukemia: If checked, complete Hairy cell and other B-cell leukemias Questionnaire.
☐ 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 applies):
☐ 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 an anemia condition, including anemia caused by treatment for a hematologic or lymphatic condition?
☐ Yes  ☐ No
  If yes, is continuous medication required for control?
  ☐ Yes  ☐ No
  If yes, list medication(s): __________________________

c. Does the Veteran have a thrombocytopenia condition, including thrombocytopenia caused by treatment for a hematologic or lymphatic condition?
☐ Yes  ☐ No
  If yes, is continuous medication required for control?
  ☐ 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
b. 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
Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?
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. Hemoglobin level (gm/100ml):________ Date: ________________

b. Platelet count: ______________ Date: ________________

c. 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: ____________________________ Phone: __________________

Medical license #: ____________________________ Physician address: ____________________________

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

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the VA Suicide Prevention Hotline at 1-800-273-TALK. Stay on the Hotline until help can link the Veteran to emergency care.

This form is for use only by VHA and VBA staff and contract psychiatrists or psychologists.

In order to conduct an initial examination for PTSD, the examiner must meet one of the following criteria:
a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

1. Diagnosis
a. Does the Veteran have a diagnosis of PTSD that conforms to DSM-IV criteria?
   ☐ Yes ☐ No
   Date of diagnosis of PTSD: ______________
   ICD code: ______________
   Name of diagnosing facility or clinician: __________________

b. If no diagnosis of PTSD, check all that apply:
   ☐ Veteran’s symptoms do not meet the diagnostic criteria for PTSD under DSM-IV criteria
   ☐ Veteran has another Axis I-IV diagnosis
      If checked, list the Axis I-IV diagnoses and then also complete the Mental Health and/or Eating Disorder Questionnaire(s):
         __________________________________________________________________________
         __________________________________________________________________________
   ☐ Other trauma spectrum disorder
   ☐ Veteran does not have a mental disorder that conforms with DSM-IV criteria
   ☐ Other (describe): __________________________________________________________________

   c. If there is a diagnosis of PTSD, does the Veteran also have any other Axis I-IV diagnoses?
      ☐ Yes ☐ No
      (If yes, indicate additional diagnoses below. There is no need to also complete the Mental Health or Eating Disorder Questionnaire)
         Additional mental health disorder diagnosis #1: ____________________________
         Date of diagnosis: ______________
         ICD code: ______________
         Name of diagnosing facility or clinician: __________________
Indicate the Axis category:

[ ] Axis I  [ ] Axis II  [ ] Axis III  [ ] Axis IV

Describe the condition and its relationship to PTSD:

Additional mental health disorder diagnosis #2: ________________________________
Date of diagnosis: _______________
ICD code: __________
Name of diagnosing facility or clinician: __________________
Indicate the Axis category:

[ ] Axis I  [ ] Axis II  [ ] Axis III  [ ] Axis IV

Describe the condition and its relationship to PTSD:

Additional mental health disorder diagnosis #3: ________________________________
Date of diagnosis: _______________
ICD code: __________
Name of diagnosing facility or clinician: __________________
Indicate the Axis category:

[ ] Axis I  [ ] Axis II  [ ] Axis III  [ ] Axis IV

Describe the condition and its relationship to PTSD:

If additional diagnoses, describe, using above format: _______________________

2. Medical history
Describe the history (including onset and course) of the Veteran’s PTSD (and other mental disorders) (brief summary):

_____________________________________________________________________________

3. Diagnostic criteria
Please check boxes next to symptoms below. The diagnostic criteria for PTSD, referred to as Criteria A-F, are from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).

Criterion A: The Veteran has been exposed to a traumatic event where both of the following were present:

[ ] The Veteran experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
[ ] The Veteran’s response involved intense fear, helplessness or horror.
[ ] No exposure to a traumatic event.

Criterion B: The traumatic event is persistently reexperienced in 1 or more of the following ways:

[ ] Recurrent and distressing recollections of the event, including images, thoughts or perceptions
[ ] Recurrent distressing dreams of the event
[ ] Acting or feeling as if the traumatic event were recurring; this includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated
[ ] Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
[ ] Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
[ ] The traumatic event is not persistently reexperienced

Criterion C: Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by 3 or more of the following:

[ ] Efforts to avoid thoughts, feelings or conversations associated with the trauma
[ ] Efforts to avoid activities, places or people that arouse recollections of the trauma
Inability to recall an important aspect of the trauma
Markedly diminished interest or participation in significant activities
Feeling of detachment or estrangement from others
Restricted range of affect (e.g., unable to have loving feelings)
Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children or a normal life span)
No persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness

**Criterion D:** Persistent symptoms of increased arousal, not present before the trauma, as indicated by 2 or more of the following:
- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response
- No persistent symptoms of increased arousal

**Criterion E:**
- The duration of the symptoms described above in Criteria B, C and D is more than 1 month.
- The duration of the symptoms described above in Criteria B, C and D is less than 1 month.
- No symptoms

**Criterion F:**
- The symptoms described above in Criteria B, C and D cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms described above in Criteria B, C and D do NOT cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- No symptoms

4. Evidence review
In order to provide an accurate medical opinion, the Veteran’s records should be reviewed, if available.

Was the Veteran’s VA claims file reviewed?
- Yes
- No

If yes, list any records that were reviewed but were not included in the Veteran’s VA claims file:

If no, check all records reviewed as part of this examination:
- Military service treatment records
- Military service personnel records
- Military enlistment examination
- Military separation examination
- Military post-deployment questionnaire
- Department of Defense Form 214 Separation Documents
- Veterans Health Administration medical records (VA treatment records)
- Civilian medical records
- Interviews with collateral witnesses (family and others who have known the veteran before and after military service)
- Other:
- No records were reviewed

5. Stressors
NOTE: For VA purposes, “fear of hostile military or terrorist activity” means that a veteran experienced, witnessed, or was confronted with an event or circumstance that involved actual or threatened death or serious injury, or a
threat to the physical integrity of the veteran or others, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft, and the veteran's response to the event or circumstance involved a psychological or psycho-physiological state of fear, helplessness, or horror.

a. Stressor #1: ___________________
Describe circumstance of stressor #1: ___________________
Are the Veteran’s symptoms related to this stressor?
☐ Yes  ☐ No
If no, explain: ___________________
Does this stressor meet Criterion A (i.e., is it adequate to support the diagnosis of PTSD)?
☐ Yes  ☐ No
Is the stressor related to the Veteran’s fear of hostile military or terrorist activity?
☐ Yes  ☐ No
If no, explain: ___________________

b. Stressor #2: ___________________
Describe circumstance of stressor #2: ___________________
Are the Veteran’s symptoms related to this stressor?
☐ Yes  ☐ No
If no, explain: ___________________
Does this stressor meet Criterion A (i.e., is it adequate to support the diagnosis of PTSD)?
☐ Yes  ☐ No
Is the stressor related to the Veteran’s fear of hostile military or terrorist activity?
☐ Yes  ☐ No
If no, explain: ___________________

c. Stressor #3: ___________________
Describe circumstance of stressor #3: ___________________
Are the Veteran’s symptoms related to this stressor?
☐ Yes  ☐ No
If no, explain: ___________________
Does this stressor meet Criterion A (i.e., is it adequate to support the diagnosis of PTSD)?
☐ Yes  ☐ No
Is the stressor related to the Veteran’s fear of hostile military or terrorist activity?
☐ Yes  ☐ No
If no, explain: ___________________

d. Additional stressors: If additional stressors describe: ________________

6. Symptoms
For each level below, check all symptoms that apply.

Level I
Does the Veteran have any symptoms from the list below?
☐ Yes  ☐ No
If yes, check all that apply:
☐ Depressed mood
☐ Anxiety
☐ Suspiciousness
☐ Panic attacks that occur weekly or less often
☐ Chronic sleep impairment
☐ Mild memory loss, such as forgetting names, directions or recent events
Level II
Does the Veteran have any symptoms from the list below?
☐ Yes  ☐ No
If yes, check all that apply:
☐ Flattened affect
☐ Circumstantial, circumlocutory or stereotyped speech
☐ Panic attacks more than once a week
☐ Difficulty in understanding complex commands
☐ Impairment of short- and long-term memory, for example, retention of only highly learned material, while forgetting to complete tasks
☐ Impaired judgment
☐ Impaired abstract thinking
☐ Disturbances of motivation and mood
☐ Difficulty in establishing and maintaining effective work and social relationships

Level III
Does the Veteran have any symptoms from the list below?
☐ Yes  ☐ No
If yes, check all that apply:
☐ Suicidal ideation
☐ Obsessional rituals which interfere with routine activities
☐ Speech intermittently illogical, obscure, or irrelevant
☐ Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively
☐ Impaired impulse control, such as unprovoked irritability with periods of violence
☐ Spatial disorientation
☐ Neglect of personal appearance and hygiene
☐ Difficulty in adapting to stressful circumstances, including work or a worklike setting
☐ Inability to establish and maintain effective relationships

Level IV
Does the Veteran have any symptoms from the list below?
☐ Yes  ☐ No
If yes, check all that apply:
☐ Gross impairment in thought processes or communication
☐ Persistent delusions or hallucinations
☐ Grossly inappropriate behavior
☐ Persistent danger of hurting self or others
☐ Intermittent inability to perform activities of daily living, including maintenance of minimal personal hygiene
☐ Disorientation to time or place
☐ Memory loss for names of close relatives, own occupation, or own name

7. Other symptoms
Does the Veteran have any other symptoms attributable to PTSD (and other mental disorders) that are not listed above?
☐ Yes  ☐ No
If yes, describe: ___________________________________________________

8. Differentiation of symptoms
Are you able to differentiate what portion of the symptom complex above is caused by each diagnosis?
☐ Yes  ☐ No
If yes, list which symptoms are attributable to each diagnosis, where possible:
__________________________________________________________________
9. Occupational and social impairment
Which of the following best represents the Veteran’s level of occupational and social impairment?
(Check only one)

☐ A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication
☐ Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by medication
☐ Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with normal routine behavior, self-care and conversation
☐ Occupational and social impairment with reduced reliability and productivity
☐ Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood
☐ Total occupational and social impairment

10. Current global assessment of functioning (GAF) score: ____________

11. Competency
Is the Veteran capable of managing his or her financial affairs?
☐ Yes  ☐ No
If no, explain: __________________________

12. Diagnostic testing
Has any mental health testing been performed?
☐ Yes  ☐ No
If yes, provide dates, types of testing and results: __________________________

13. Functional impact
Does the Veteran’s PTSD (and other mental disorders) impact his or her ability to work?
☐ Yes  ☐ No
If yes, describe impact, providing one or more examples:
__________________________________________________

14. Remarks, if any
______________________________________________
______________________________________________

Psychiatrist/Psychologist signature & title: _________________________________ Date: __________
Psychiatrist/Psychologist printed name: ___________________________________ Phone: _________
License #: __________________ Psychiatrist/Psychologist address: ________________________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
5.4 Mental Disorders (Other than PTSD and Eating Disorders) 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.

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the VA Suicide Prevention Hotline at 1-800-273-TALK. Stay on the Hotline until help can link the Veteran to emergency care.

NOTE: In order to conduct an initial examination for mental disorders, the examiner must meet one of the following criteria: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

In order to conduct a REVIEW examination for mental disorders, the examiner must meet one of the criteria from above, OR be a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a mental disorder(s)?

Yes  No

NOTE: If the Veteran has a diagnosis of an eating disorder, complete the Eating Disorder Questionnaire in lieu of this Questionnaire.

NOTE: If the Veteran has a diagnosis of PTSD, the PTSD Questionnaire must be completed by a VHA staff or contract examiner in lieu of this Questionnaire.

If no, provide rationale (e.g., Veteran does not currently have any diagnosed mental disorders):

__________________________________________________________________________

If the Veteran has more than one mental health diagnosis, provide all diagnoses:

Diagnosis #1: ________________________________
ICD code: ________________
Date of diagnosis: ________________
Name of diagnosing facility or clinician: ________________________________

Diagnosis #2: ________________________________
ICD code: ________________
Date of diagnosis: ________________
Name of diagnosing facility or clinician: ________________________________
Diagnosis #3: ______________________
ICD code: __________
Date of diagnosis: __________________
Name of diagnosing facility or clinician: __________________

If additional diagnoses that pertain to mental health disorders, list using above format:

2. Medical history
Describe the history (including onset and course) of the Veteran’s mental conditions (brief summary):

3. Symptoms
For each level below, check all symptoms that apply.

Level I
Does the Veteran have any symptoms from the list below?  Yes  No
If yes, check all that apply:
- Depressed mood
- Anxiety
- Suspiciousness
- Panic attacks that occur weekly or less often
- Chronic sleep impairment
- Mild memory loss, such as forgetting names, directions or recent events

Level II
Does the Veteran have any symptoms from the list below?  Yes  No
If yes, check all that apply:
- Flattened affect
- Circumstantial, circumlocutory or stereotyped speech
- Panic attacks more than once a week
- Difficulty in understanding complex commands
- Impairment of short- and long-term memory, for example, retention of only highly learned material, while forgetting to complete tasks
- Impaired judgment
- Impaired abstract thinking
- Disturbances of motivation and mood
- Difficulty in establishing and maintaining effective work and social relationships

Level III
Does the Veteran have any symptoms from the list below?  Yes  No
If yes, check all that apply:
- Suicidal ideation
- Obsessional rituals which interfere with routine activities
- Speech intermittently illogical, obscure, or irrelevant
- Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively
- Impaired impulse control, such as unprovoked irritability with periods of violence
- Spatial disorientation
- Neglect of personal appearance and hygiene
- Difficulty in adapting to stressful circumstances, including work or a worklike setting
- Inability to establish and maintain effective relationships

Level IV
Does the Veteran have any symptoms from the list below?  Yes  No
If yes, check all that apply:
- Gross impairment in thought processes or communication
- Persistent delusions or hallucinations
- Grossly inappropriate behavior
- Persistent danger of hurting self or others
- Intermittent inability to perform activities of daily living, including maintenance of minimal personal hygiene
- Disorientation to time or place
- Memory loss for names of close relatives, own occupation, or own name

4. Other symptoms
Does the Veteran have any other symptoms attributable to mental disorders that are not listed above?
Yes  No
If yes, describe: ___________________________________________________

5. Differentiation of symptoms
Are you able to differentiate what portion of the symptom complex above is caused by each diagnosis?
☐ Yes  ☐ No
If yes, list which symptoms are attributable to each diagnosis, where possible:

_________________________________________________________________

6. Occupational and social impairment
Which of the following best represents the Veteran’s level of occupational and social impairment?
(Check only one)
- A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication
- Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by medication
- Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with normal routine behavior, self-care and conversation
- Occupational and social impairment with reduced reliability and productivity
- Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood
- Total occupational and social impairment

7. Current global assessment of functioning (GAF) score: __________

8. Competency
Is the Veteran capable of managing his or her financial affairs?
Yes  No
If no, explain: __________________________

9. Diagnostic testing
Has any mental health testing been performed?
☐ Yes  ☐ No
If yes, provide dates, types of testing and results: __________________________

10. Functional impact
Does the Veteran’s mental disorder(s) impact his or her ability to work?
Yes  No
If yes, describe impact, providing one or more examples:

__________________________________________________________________________________________________________________________________________

11. Remarks, if any

Psychiatrist/Psychologist/examiner signature & title: ______________________ Date: _________________
Psychiatrist/Psychologist/examiner printed name: ___________________________ Phone: ________________
License #: __________________ Psychiatrist/Psychologist/examiner address: ___________________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
5.5 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 current 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
☐ 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 most recent treatment: ___________
Date of completion of treatment or anticipated date of completion: ___________
☐ Androgen Deprivation Therapy (Hormonal Therapy)
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: ___________

4. **Residual conditions and/or complications**
   a. Does the Veteran have any residual conditions and/or complications due to prostate cancer or treatment for prostate cancer?
      ☐ Yes  ☐ No
      If yes, complete the following sections:

   b. Does the Veteran have voiding dysfunction causing urine leakage?
      ☐ Yes  ☐ No
      If yes, check one:
         ☐ Does not require/does not use absorbent material
         ☐ Requires absorbent material that is changed less than 2 times per day
         ☐ Requires absorbent material that is changed 2 to 4 times per day
         ☐ Requires absorbent material that is changed more than 4 times per day

   c. Does the Veteran have voiding dysfunction causing signs and/or symptoms of 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 Veteran have voiding dysfunction causing findings, signs and/or symptoms of obstructed voiding?
      ☐ Yes  ☐ No
      If yes, check all signs and symptoms 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 or continuous catheterization

   e. Does the Veteran have voiding dysfunction requiring the use of an appliance?
      ☐ Yes  ☐ No
      If yes, describe: ______________________________________________________________
f. Does the Veteran have a history of recurrent symptomatic urinary tract infections?
   ☐ Yes ☐ No
   If yes, check all treatments that apply:
   ☐ No treatment
   ☐ Long-term drug therapy
      If checked, list medications used for urinary tract infection and indicate dates for courses of treatment over
      the past 12 months: ________________________________
   ☐ Hospitalization
      If checked, indicate frequency of hospitalization:
      ☐ 1 or 2 per year
      ☐ More than 2 per year
   ☐ Drainage
      If checked, indicate dates when drainage performed over past 12 months: ________________________________
   ☐ Intensive management
      If checked, indicate frequency of management:
      ☐ Continuous
      ☐ Intermittent

  g. Does the Veteran have erectile dysfunction?
     ☐ Yes ☐ No
     If yes, is the erectile dysfunction as likely as not (at least a 50% probability) attributable to prostate cancer,
     including treatment or residuals of treatment for prostate cancer?
     ☐ Yes ☐ No
     If no, provide the etiology of the erectile dysfunction: ____________________________________________
     If yes, is the Veteran able to achieve an erection (without medication) sufficient for penetration and
     ejaculation?
     ☐ Yes ☐ No
     If no, is the Veteran able to achieve an erection (with medication) sufficient for penetration and ejaculation?
     ☐ Yes ☐ No

h. Does the Veteran have any other residual complications of prostate cancer or treatment for prostate cancer?
   ☐ Yes ☐ No
   If yes, describe: _____________________________________________________________________

5. Other pertinent physical findings, complications, conditions, signs and/or symptoms
   Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?
   ☐ Yes ☐ No
   If yes, describe: _____________________________________________________________________

6. 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): _________________

7. 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: ______________

8. Remarks, if any

Physician signature: ____________________________ Date: ______________________
Physician printed name: _____________________________________ Phone: ___________________
Medical license #: ______________ Physician address: __________________________________

**NOTE:** VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
5.6 Review PTSD 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.

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the VA Suicide Prevention Hotline at 1-800-273-TALK. Stay on the Hotline until help can link the Veteran to emergency care.

In order to conduct an initial or review examination for PTSD, the examiner must meet one of the following criteria: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

In order to conduct a REVIEW examination for PTSD, the examiner must meet one of the criteria from above, OR be a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

1. Diagnosis
   a. Does the Veteran have a diagnosis of PTSD that conforms with DSM-IV criteria?

   □ Yes    □ No
   Date of diagnosis of PTSD: __________  ICD code: __________
   Name of diagnosing facility or clinician: __________________

   b. If no diagnosis of PTSD, check all that apply:

   □ Veteran’s symptoms do not meet the diagnostic criteria for PTSD under DSM-IV criteria
   □ Veteran has another Axis I-IV diagnosis
       If checked, list the Axis I-IV diagnoses and then also complete the Mental Health and/or Eating Disorder Questionnaire(s): ___________________________________________________________

   □ Other trauma spectrum disorder
   □ Veteran does not have a mental disorder that conforms with DSM-IV criteria
   □ Other (describe): _______________________________________________________

   c. If there is a diagnosis of PTSD, does the Veteran also have any other Axis I-IV diagnoses?

   □ Yes    □ No
   (If yes, indicate additional diagnoses below. There is no need to also complete a Mental Health or Eating Disorder Questionnaire)

       Additional mental health disorder diagnosis #1: _____________________________
       Date of diagnosis: ________________
ICD code: __________
Name of diagnosing facility or clinician: __________________
Indicate the Axis category:
☐ Axis I  ☐ Axis II  ☐ Axis III  ☐ Axis IV
Describe the condition and its relationship to PTSD:
_________________________________________________________

Additional mental health disorder diagnosis #2: ______________________
Date of diagnosis: _______________
ICD code: __________
Name of diagnosing facility or clinician: __________________
Indicate the Axis category:
☐ Axis I  ☐ Axis II  ☐ Axis III  ☐ Axis IV
Describe the condition and its relationship to PTSD:
_________________________________________________________

Additional mental health disorder diagnosis #3: ______________________
Date of diagnosis: _______________
ICD code: __________
Name of diagnosing facility or clinician: __________________
Indicate the Axis category:
☐ Axis I  ☐ Axis II  ☐ Axis III  ☐ Axis IV
Describe the condition and its relationship to PTSD:
_________________________________________________________

If additional diagnoses, describe, using above format: ______________

2. Medical history
Describe the history (including onset and course) of the Veteran's PTSD (and other mental disorders) (brief summary):
_____________________________________________________________________________

3. Diagnostic criteria
Please check boxes next to symptoms below. The diagnostic criteria for PTSD, referred to as Criteria A-F, are from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).

Criterion A: The Veteran has been exposed to a traumatic event where both of the following were present:
☐ The Veteran experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
☐ The Veteran's response involved intense fear, helplessness or horror.
☐ No exposure to a traumatic event

Criterion B: The traumatic event is persistently reexperienced in 1 or more of the following ways:
☐ Recurrent and distressing recollections of the event, including images, thoughts or perceptions
☐ Recurrent distressing dreams of the event
☐ Acting or feeling as if the traumatic event were recurring; this includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated
☐ Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
☐ Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
☐ The traumatic event is not persistently reexperienced

Criterion C: Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by 3 or more of the following:
☐ Efforts to avoid thoughts, feelings or conversations associated with the trauma
Efforts to avoid activities, places or people that arouse recollections of the trauma
Inability to recall an important aspect of the trauma
Markedly diminished interest or participation in significant activities
Feeling of detachment or estrangement from others
Restricted range of affect (e.g., unable to have loving feelings)
Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children or a normal life span)
No persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness

**Criterion D:** Persistent symptoms of increased arousal, not present before the trauma, as indicated by 2 or more of the following:
- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response
- No persistent symptoms of increased arousal

**Criterion E:**
- The duration of the symptoms described above in Criteria B, C and D is more than 1 month.
- The duration of the symptoms described above in Criteria B, C and D is less than 1 month.
- No symptoms

**Criterion F:**
- The symptoms described above in Criteria B, C and D cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms described above in Criteria B, C and D do NOT cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- No symptoms

4. **Symptoms**

For each level below, check all symptoms that apply.

**Level I**

Does the Veteran have any symptoms from the list below? □ Yes □ No
If yes, check all that apply:
- Depressed mood
- Anxiety
- Suspiciousness
- Panic attacks that occur weekly or less often
- Chronic sleep impairment
- Mild memory loss, such as forgetting names, directions or recent events

**Level II**

Does the Veteran have any symptoms from the list below? □ Yes □ No
If yes, check all that apply:
- Flattened affect
- Circumstantial, circumlocutory or stereotyped speech
- Panic attacks more than once a week
- Difficulty in understanding complex commands
- Impairment of short- and long-term memory, for example, retention of only highly learned material, while forgetting to complete tasks
- Impaired judgment
- Impaired abstract thinking
- Disturbances of motivation and mood
- Difficulty in establishing and maintaining effective work and social relationships
Level III
Does the Veteran have any symptoms from the list below?  □ Yes  □ No
If yes, check all that apply:
- [ ] Suicidal ideation
- [ ] Obsessional rituals which interfere with routine activities
- [ ] Speech intermittently illogical, obscure, or irrelevant
- [ ] Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively
- [ ] Impaired impulse control, such as unprovoked irritability with periods of violence
- [ ] Spatial disorientation
- [ ] Neglect of personal appearance and hygiene
- [ ] Difficulty in adapting to stressful circumstances, including work or a worklike setting
- [ ] Inability to establish and maintain effective relationships

Level IV
Does the Veteran have any symptoms from the list below?  □ Yes  □ No
If yes, check all that apply:
- [ ] Gross impairment in thought processes or communication
- [ ] Persistent delusions or hallucinations
- [ ] Grossly inappropriate behavior
- [ ] Persistent danger of hurting self or others
- [ ] Intermittent inability to perform activities of daily living, including maintenance of minimal personal hygiene
- [ ] Disorientation to time or place
- [ ] Memory loss for names of close relatives, own occupation, or own name

5. Other symptoms
Does the Veteran have any other symptoms attributable to PTSD (and other mental disorders) that are not listed above?  □ Yes  □ No
If yes, describe: ___________________________________________________

6. Differentiation of symptoms
Are you able to differentiate what portion of the symptom complex above is caused by each diagnosis?  □ Yes  □ No
If yes, list which symptoms are attributable to each diagnosis, where possible:
_________________________________________________________________

7. Occupational and social impairment
Which of the following best represents the Veteran’s level of occupational and social impairment?
(Check only one)
- [ ] A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication
- [ ] Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by medication
- [ ] Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with normal routine behavior, self-care and conversation
- [ ] Occupational and social impairment with reduced reliability and productivity
- [ ] Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood
- [ ] Total occupational and social impairment
8. Current global assessment of functioning (GAF) score: ____________

9. Competency
Is the Veteran capable of managing his or her financial affairs?
☐ Yes  ☐ No
If no, explain: ______________________________

10. Diagnostic testing
Has any mental health testing been performed?
☐ Yes  ☐ No
If yes, provide dates, types of testing and results: ______________________________

11. Functional impact
Does the Veteran’s PTSD and/or other mental disorder(s) impact his or her ability to work?
☐ Yes  ☐ No
If yes, describe impact, providing one or more examples:
________________________________________________________________________

12. Remarks, if any
________________________________________________________________________

Psychiatrist/Psychologist/examiner signature & title: __________________________Date: ______
Psychiatrist/Psychologist/examiner printed name: ___________________________Phone: ______
License #: ____________ Psychiatrist/Psychologist/examiner address: __________________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6. Software and Documentation Retrieval

6.1 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*161.

6.2 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:

<table>
<thead>
<tr>
<th>OI&amp;T Field Office</th>
<th>FTP Address</th>
<th>Directory</th>
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<tbody>
<tr>
<td>Albany</td>
<td>ftp.fo-albany.med.va.gov</td>
<td>[anonymous.software]</td>
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<tr>
<td>Hines</td>
<td>ftp.fo-hines.med.va.gov</td>
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<td>ftp.fo-slc.med.va.gov</td>
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The following files will be available:

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<th>File Name</th>
<th>Format</th>
<th>Description</th>
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<tbody>
<tr>
<td>DVBA_27_P161_RN.PDF</td>
<td>Binary</td>
<td>Release Notes</td>
</tr>
</tbody>
</table>

Documentation may also be retrieved from the VistA Documentation Library (VDL) on the Internet at the following address. This web site is usually updated within 1-3 days of the patch release date. [http://www4.va.gov/vdl/application.asp?appid=133](http://www4.va.gov/vdl/application.asp?appid=133).

6.3 Related Documents

The following related documents are available for download from the VistA Documentation Library (VDL). The VDL web address for CAPRI documentation is: [http://www.va.gov/vdl/application.asp?appid=133](http://www.va.gov/vdl/application.asp?appid=133).

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