



**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:

- |   |                 |                          |
|---|-----------------|--------------------------|
| <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 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

- At least once every 3 months
- At least once every 6 weeks

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?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_

**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:

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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:

OI&T Field Office	FTP Address	Directory
Albany	<a href="ftp.fo-albany.med.va.gov">ftp.fo-albany.med.va.gov</a>	[anonymous.software]
Hines	<a href="ftp.fo-hines.med.va.gov">ftp.fo-hines.med.va.gov</a>	[anonymous.software]
Salt Lake City	<a href="ftp.fo-slc.med.va.gov">ftp.fo-slc.med.va.gov</a>	[anonymous.software]

The following files will be available:

File Name	Format	Description
DVBA_27_P161_RN.PDF	Binary	Release Notes

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>

## 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>.

File Name	Description
DVBA_27_P161_DBQ_EATINGDISORDERS_WF.DOC	Workflow Document
DVBA_27_P161_DBQ_HEMICANDLYMPHATIC_WF.DOC	Workflow Document
DVBA_27_P161_DBQ_IHD_WF.DOC	Workflow Document
DVBA_27_P161_DBQ_INITIALPTSD_WF.DOC	Workflow Document
DVBA_27_P161_DBQ_MENTALDISORDERS_WF.DOC	Workflow Document
DVBA_27_P161_DBQ_PROSTATECANCER_WF.DOC	Workflow Document
DVBA_27_P161_DBQ_REVIEWPTSD_WF.DOC	Workflow Document