

Compensation and Pension Record Interchange (CAPRI)

Hematologic and Lymphatic Conditions, including Leukemia

Disability Benefits Questionnaire (DBQ)

Workflow

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Table of Contents

[1 Introduction 1](#_Toc289339839)

[1.1 Purpose 1](#_Toc289339840)

[1.2 Overview 1](#_Toc289339841)

[2 Hematologic and Lymphatic Conditions DBQ 2](#_Toc289339842)

[2.1 Name of patient/Veteran 2](#_Toc289339843)

[2.2 Section 1. Diagnosis 3](#_Toc289339844)

[2.3 Section 2. Medical history 10](#_Toc289339845)

[2.4 Section 3. Treatment 11](#_Toc289339846)

[2.5 Section 4. Conditions, complications and/or residuals 18](#_Toc289339847)

[2.6 Section 5. Recurring infections 22](#_Toc289339848)

[2.7 Section 6. Thrombocytopenia (primary, idiopathic or immune) 23](#_Toc289339849)

[2.8 Section 7. Polycythemia vera 25](#_Toc289339850)

[2.9 Section 8. Sickle cell anemia 27](#_Toc289339851)

[2.10 Section 9. Other pertinent physical findings, complications, conditions, signs and/or symptoms 28](#_Toc289339852)

[2.11 Section 10. Diagnostic testing 30](#_Toc289339853)

[2.12 Section 11. Functional impact 32](#_Toc289339854)

[2.13 Section 12. Remarks, if any 34](#_Toc289339855)

[3 Hemic and Lymphatic DBQ-AMIE Worksheet 35](#_Toc289339856)

Table of Figures and Tables

[Figure 1: Template Example: DBQ - Standard VA Note 1](#_Toc289339857)

[Figure 2: Print Example: DBQ – Standard VA Note 1](#_Toc289339858)

[Figure 3: Template Example: DBQ – Hemic and Lymphatic – Name of patient/Veteran 2](#_Toc289339859)

[Figure 4: Print Example: DBQ – Hemic and Lymphatic – Name of patient/Veteran 2](#_Toc289339860)

[Figure 5: Template Example: DBQ – Hemic and Lymphatic – 1. Diagnosis 9](#_Toc289339861)

[Figure 6: Print Example: DBQ – Hemic and Lymphatic – 1. Diagnosis 10](#_Toc289339862)

[Figure 7: Template Example: DBQ – Hemic and Lymphatic – 2. Medical history 11](#_Toc289339863)

[Figure 8: Print Example: DBQ – Hemic and Lymphatic – 2. Medical history 11](#_Toc289339864)

[Figure 9: Template Example: DBQ – Hemic and Lymphatic – 3. Treatment 16](#_Toc289339865)

[Figure 10: Print Example: DBQ – Hemic and Lymphatic – 3. Treatment 18](#_Toc289339866)

[Figure 11: Template Example: DBQ – Hemic and Lymphatic – 4. Conditions, complications and/or residuals 21](#_Toc289339867)

[Figure 12: Print Example: DBQ – Hemic and Lymphatic – 4. Conditions, complications and/or residuals 21](#_Toc289339868)

[Figure 13: Template Example: DBQ – Hemic and Lymphatic – 5. Recurring infections 22](#_Toc289339869)

[Figure 14: Print Example: DBQ – Hemic and Lymphatic – 5. Recurring infections 22](#_Toc289339870)

[Figure 15: Template Example: DBQ – Hemic and Lymphatic – 6. Thrombocytopenia (primary, idiopathic or immune) 24](#_Toc289339871)

[Figure 16: Print Example: DBQ – Hemic and Lymphatic – 6. Thrombocytopenia (primary, idiopathic or immune) 25](#_Toc289339872)

[Figure 17: Template Example: DBQ – Hemic and Lymphatic – 7. Polycythemia vera 26](#_Toc289339873)

[Figure 18: Print Example: DBQ – Hemic and Lymphatic – 7. Polycythemia vera 26](#_Toc289339874)

[Figure 19: Template Example: DBQ – Hemic and Lymphatic – 8. Sickle cell anemia 28](#_Toc289339875)

[Figure 20: Print Example: DBQ – Hemic and Lymphatic – 8. Sickle cell anemia 28](#_Toc289339876)

[Figure 21: Template Example: DBQ – Hemic and Lymphatic – 9. Other pertinent physical findings, complications, conditions, signs and/or symptoms 29](#_Toc289339877)

[Figure 22: Print Example: DBQ – Hemic and Lymphatic – 9. Other pertinent physical findings, complications, conditions, signs and/or symptoms 30](#_Toc289339878)

[Figure 23: Template Example: DBQ – Hemic and Lymphatic – 10. Diagnostic testing 32](#_Toc289339879)

[Figure 24: Print Example: DBQ – Hemic and Lymphatic – 10. Diagnostic testing 32](#_Toc289339880)

[Figure 25: Template Example: DBQ – Hemic and Lymphatic – 11. Functional impact 33](#_Toc289339881)

[Figure 26: Print Example: DBQ – Hemic and Lymphatic – 11. Functional impact 33](#_Toc289339882)

[Figure 27: Template Example: DBQ – Hemic and Lymphatic – 12. Remarks, if any 34](#_Toc289339883)

[Figure 28: Print Example: DBQ – Hemic and Lymphatic – 12. Remarks, if any 34](#_Toc289339884)

[Table 1: Rules: DBQ – Hemic and Lymphatic – Name of patient/Veteran 2](#_Toc289339885)

[Table 2: Rules: DBQ – Hemic and Lymphatic – 1. Diagnosis 3](#_Toc289339886)

[Table 3: Rules: DBQ – Hemic and Lymphatic – 2. Medical history 11](#_Toc289339887)

[Table 4: Rules: DBQ – Hemic and Lymphatic – 3. Treatment 12](#_Toc289339888)

[Table 5: Rules: DBQ – Hemic and Lymphatic – 4. Conditions, complications and/or residuals 19](#_Toc289339889)

[Table 6: Rules: DBQ – Hemic and Lymphatic – 5. Recurring infections 22](#_Toc289339890)

[Table 7: Rules: DBQ – Hemic and Lymphatic – 6. Thrombocytopenia (primary, idiopathic or immune) 24](#_Toc289339891)

[Table 8: Rules: DBQ – Hemic and Lymphatic – 7. Polycythemia vera 26](#_Toc289339892)

[Table 9: Rules: DBQ – Hemic and Lymphatic – 8. Sickle cell anemia 27](#_Toc289339893)

[Table 10: Rules: DBQ – Hemic and Lymphatic – 9. Other pertinent physical findings, complications, conditions, signs and/or symptoms 29](#_Toc289339894)

[Table 11: Rules: DBQ – Hemic and Lymphatic – 10. Diagnostic testing 31](#_Toc289339895)

[Table 12: Rules: DBQ – Hemic and Lymphatic – 11. Functional impact 33](#_Toc289339896)

[Table 13: Rules: DBQ – Hemic and Lymphatic – 12. Remarks, if any 34](#_Toc289339897)

# Introduction

## Purpose

This document provides a high level overview of the contents found on the Hematologic and Lymphatic Conditions, including Leukemia Disability Benefits Questionnaire (DBQ). The DBQ can be populated via an online template within the CAPRI C&P Worksheets tab and then printed OR it can be printed via AMIE (AUTOMATED MEDICAL INFORMATION EXCHANGE) and then manually populated. This document contains the edit rules for the template as well as an example of how the template will look online in CAPRI or printed from CAPRI. It also contains the layout for the AMIE worksheet to depict how it will look when printed from AMIE.

For more detailed information on standard template functionality not covered in this document, please refer to the *C&P Worksheet Tab Functionalities*section of the[**CAPRI GUI User Guide**](http://www4.va.gov/vdl/documents/Financial_Admin/CAPRI/capri_um.pdf)**.**

## Overview

The Hematologic and Lymphatic Conditions, including Leukemia DBQ provides the ability to capture information related to Hematologic and Lymphatic Conditions (including Leukemia) and its treatment.

Each DBQ template contains a standard footer containing a note stating that “VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.” (see Figure 1 and 2).

Figure 1: Template Example: DBQ - Standard VA Note



Figure 2: Print Example: DBQ – Standard VA Note

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

A number of fields on the Hematologic and Lymphatic Conditions template are mandatory and require a response (value) prior to the exam being marked as completed. Some questions may activate a Pop-up window displaying information as to each question that needs to be answered before the template can be completed.

# Hematologic and Lymphatic Conditions DBQ

## Name of patient/Veteran

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 1: Rules: DBQ – Hemic and Lymphatic – Name of patient/Veteran

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **Hematologic and Lymphatic Conditions,****including Leukemia** | Enabled, Read-Only | N/A | N/A | N/A |
| **Disability Benefits Questionnaire** | Enabled, Read-Only | N/A | N/A | N/A |
| Name of patient/Veteran: | Enabled, Mandatory  | N/A | Free Text | Please enter the name of the patient/Veteran. |
| **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.**  | Enabled, Read-Only | N/A | N/A | N/A |

Figure 3: Template Example: DBQ – Hemic and Lymphatic – Name of patient/Veteran



Figure 4: Print Example: DBQ – Hemic and Lymphatic – Name of patient/Veteran

|  |
| --- |
|  Hematologic and Lymphatic Conditions, |
|  including LeukemiaDisability Benefits Questionnaire |
|  |
|  Name of patient/Veteran:  |
|   |
|  Your patient is applying to the U.S. Department of Veterans Affairs (VA) for  |
|  disability benefits. VA will consider the information you provide on this  |
|  questionnaire as part of their evaluation in processing the Veteran's claim. |

## Section 1. Diagnosis

The question “Does the Veteran now have or has he/she ever been diagnosed with a hematologic and/or lymphatic condition?” must be answered before the template can be completed.

* If it is answered with Yes, all other questions requiring an answer as described by the rules in this document must be answered before the template can be completed.
* If it is answered with No, the rationale supporting this is required. The remainder of the template may be completed without answering any additional questions or the user may input answers to any of the optional questions as indicated by the rules described in this document.

All questions will be printed even if they have not been answered.

If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below and must be answered before this template can be completed.

Table 2: Rules: DBQ – Hemic and Lymphatic – 1. Diagnosis

| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| --- | --- | --- | --- | --- |
| **1.Diagnosis** | Enabled, Read-Only | N/A | N/A | N/A |
| Does the Veteran now have or has he/she ever been diagnosed with a hematologic and/or lymphatic condition?  | Enabled, Mandatory, Choose one valid value | [Yes; No] | N/A | Please answer the question: Does the Veteran now have or has he/she ever been diagnosed with a hematologic and/or lymphatic condition?  |
| If no, provide rationale (e.g., Veteran does not currently have any known hematologic or lymphatic condition(s)): | If *Diagnosis* = *No*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please provide the rationale for stating the Veteran has never been diagnosed with a hematologic and/or lymphatic condition. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If yes, select the Veteran’s condition: | If *Diagnosis* = *Yes*; Enabled, Mandatory, Choose one or more valid valuesElse; Disabled | [Acute lymphocytic leukemia (ALL);Acute myelogenous leukemia (AML);Chronic myelogenous leukemia (CML);Hodgkin’s disease;Non-Hodgkin’s lymphoma;Anemia;Thrombocytopenia;Polycythemia vera;Sickle cell anemia;Splenectomy;Hairy cell or other B-cell leukemia: If checked, complete Hairy cell and other B-cell leukemias Questionnaire.;Other hematologic or lymphatic condition(s):] | N/A | Please select the Veteran's condition. |
| Acute lymphocytic leukemia (ALL) ICD code: | If *Acute lymphocytic leukemia (ALL)* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Acute lymphocytic leukemia (ALL). |
| Acute lymphocytic leukemia (ALL) Date of diagnosis: | If *Acute lymphocytic leukemia (ALL)* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Acute lymphocytic leukemia (ALL). |
| Acute myelogenous leukemia (AML) ICD code: | If *Acute myelogenous leukemia (AML)* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Acute myelogenous leukemia (AML). |
| Acute myelogenous leukemia (AML) Date of diagnosis: | If *Acute myelogenous leukemia (AML)* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Acute myelogenous leukemia (AML). |
| Chronic myelogenous leukemia (CML) ICD code: | If *Chronic myelogenous leukemia (CML)* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Chronic myelogenous leukemia (CML). |
| Chronic myelogenous leukemia (CML) Date of diagnosis: | If *Chronic myelogenous leukemia (CML)* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Chronic myelogenous leukemia (CML). |
| Hodgkin’s disease ICD code: | If *Hodgkin’s disease* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Hodgkin's disease. |
| Hodgkin’s disease Date of diagnosis: | If Hodgkin’s disease = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Hodgkin's disease. |
| Non-Hodgkin’s lymphoma ICD code: | If *Non-Hodgkin’s lymphoma* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Non-Hodgkin's lymphoma. |
| Non-Hodgkin’s lymphoma Date of diagnosis: | If *Non-Hodgkin’s lymphoma* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Non-Hodgkin's lymphoma. |
| Anemia ICD code: | If *Anemia* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Anemia. |
| Anemia Date of diagnosis: | If *Anemia* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Anemia. |
| Thrombocytopenia ICD code: | If *Thrombocytopenia* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Thrombocytopenia. |
| Thrombocytopenia Date of diagnosis: | If *Thrombocytopenia* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Thrombocytopenia. |
| Polycythemia vera ICD code: | If *Polycythemia vera* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Polycythemia vera. |
| Polycythemia vera Date of diagnosis: | If *Polycythemia vera* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Polycythemia vera. |
| Sickle cell anemia ICD code: | If *Sickle cell anemia* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Sickle cell anemia. |
| Sickle cell anemia Date of diagnosis: | If *Sickle cell anemia* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Sickle cell anemia. |
| Splenectomy ICD code: | If *Splenectomy* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the ICD code for Splenectomy. |
| Splenectomy Date of diagnosis: | If *Splenectomy* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of diagnosis for Splenectomy. |
| Other diagnosis #1: | If *Other hematologic or lymphatic condition(s)*= *Yes*; Enabled, MandatoryElse; Enabled, Optional | N/A | Free Text | Please enter a value in the 'Other diagnosis #1' field. |
| ICD code: | If *Other hematologic or lymphatic condition(s) = Yes;* Enabled, MandatoryElse; Enabled , Optional | N/A | Free Text | Please enter the ICD code for other diagnosis #1. |
| Date of diagnosis: | If *Other hematologic or lymphatic condition(s) = Yes;* Enabled, MandatoryElse; Enabled, Optional | N/A | Free Text | Please enter the date of diagnosis for other diagnosis #1. |
| Other diagnosis #2: | Enabled, Optional | N/A | Free Text | N/A |
| ICD code: | If *Other diagnosis #2 is populated* and *Diagnosis = Yes;* Enabled, MandatoryElse; Enabled, Optional | N/A | Free Text | Please enter the ICD code for other diagnosis #2. |
| Date of diagnosis: | If *Other diagnosis #2 is populated* and *Diagnosis = Yes;* Enabled, MandatoryElse; Enabled, Optional | N/A | Free Text | Please enter the date of diagnosis for other diagnosis #2. |
| Other diagnosis #3: | Enabled, Optional | N/A | Free Text | N/A |
| ICD code: | If *Other diagnosis #3 is populated* and *Diagnosis = Yes;* Enabled, MandatoryElse; Enabled, Optional | N/A | Free Text | Please enter the ICD code for other diagnosis #3. |
| Date of diagnosis: | If *Other diagnosis #3 is populated* and *Diagnosis = Yes;* Enabled, MandatoryElse; Enabled, Optional | N/A | Free Text | Please enter the date of diagnosis for other diagnosis #3. |
| If there are additional diagnoses that pertain to hematologic or lymphatic condition(s), list using above format: | Enabled, Optional | N/A | Free Text | N/A |

Figure 5: Template Example: DBQ – Hemic and Lymphatic – 1. Diagnosis







Figure 6: Print Example: DBQ – Hemic and Lymphatic – 1. Diagnosis

|  |
| --- |
| 1. Diagnosis |
|  ------------ |
|  Does the Veteran now have or has he/she ever been diagnosed with a  |
|  hematologic and/or lymphatic condition? [X] Yes [ ] No |
|   |
|  If no, provide rationale (e.g., Veteran does not currently have any known  |
|  hematologic or lymphatic conditions(s)):  |
|   |
|  If yes, select the Veteran's condition: |
|  [X] 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:  |

## Section 2. Medical history

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 3: Rules: DBQ – Hemic and Lymphatic – 2. Medical history

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **2.Medical history** | Enabled, Read Only | N/A | N/A | N/A |
| a. Describe the history (including onset, course and status) of the Veteran’s current condition(s) (brief summary): | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled, MandatoryElse; Enabled, Optional | N/A | Free Text | Please describe the history (including onset and course) of the Veteran's current condition(s). |
| b. Indicate the status of the primary condition:  | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled*,* Mandatory, Choose one valid valueElse; Enabled, Optional | [Active;Remission;Not applicable] | N/A | Please indicate the status of the disease. |

Figure 7: Template Example: DBQ – Hemic and Lymphatic – 2. Medical history



Figure 8: Print Example: DBQ – Hemic and Lymphatic – 2. Medical history

|  |
| --- |
|  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 |

## Section 3. Treatment

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 4: Rules: DBQ – Hemic and Lymphatic – 3. Treatment

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **3.Treatment** | Enabled, Read Only | N/A | N/A | N/A |
| a. Has the Veteran completed any treatment or is the Veteran currently undergoing any treatment for any lymphatic or hematologic condition, including leukemia? | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled*,* Mandatory, Choose one valid valueElse; Enabled, Optional | [Yes; No, watchful waiting] | N/A | Please answer the question: Has the Veteran completed any treatment or is the Veteran currently undergoing any treatment for any lymphatic or hematologic condition, including leukemia? |
| If yes, indicate treatment type(s) (check all that apply): | If *the previous question* = Yes; Enabled, Mandatory; Choose one or more valid valuesElse; Disabled | [Treatment completed, currently in watchful waiting status;Bone marrow transplant ;Surgery; Radiation therapy ; Antineoplastic chemotherapy; Other therapeutic procedure and/or treatment (describe):]  | Free Text | Please check at least one applicable treatment type. |
| Date of hospital admission and location:  | If *treatment* *types include Bone marrow transplant*; Enabled, MandatoryElse; Disabled | N/A | Free Text | For the bone marrow transplant, please provide the date of hospital admission and location. |
| Date of hospital discharge after transplant: ­­­­­­­­­­­­ | If *treatment types* *include Bone marrow transplant*; Enabled, MandatoryElse; Disabled | N/A | Free Text | For the bone marrow transplant, please provide the date of hospital discharge after transplant. |
| If checked, describe:  | If *treatment type includes* *Surgery*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please describe the surgical procedure performed. |
| Date(s) of surgery: | If *treatment types include* *Surgery*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of surgery. |
| Date of most recent treatment:  | If *treatment types include* *Radiation therapy*;Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of the most recent radiation therapy treatment. |
| Date of completion of treatment or anticipated date of completion:  | If *treatment types include* *Radiation therapy*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the radiation therapy's date of completion (actual or anticipated). |
| Date of most recent treatment:  | If *treatment types include* *Antineoplastic chemotherapy*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of the most recent antineoplastic chemotherapy treatment. |
|  Date of completion of treatment or anticipated date of completion: ­­­­­­­­­­­­ | If *treatment types include* *Antineoplastic chemotherapy*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the antineoplastic chemotherapy treatment's date of completion (actual or anticipated). |
|  Other therapeutic procedure and/or treatment (describe):   | If *treatment types include* *Other therapeutic procedure and/or treatment*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please describe the other therapeutic procedure and/or treatment performed. |
|  Date of procedure: | If *treatment types include* *Other therapeutic procedure and/or treatment*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of the most recent other therapeutic procedure and/or treatment. |
|  Date of completion of treatment or anticipated date of completion: ­­­­­­­­­­­­ | If *treatment types include* *Other therapeutic procedure and/or treatment*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please enter the date of completion (actual or anticipated) of the other therapeutic procedure and/or treatment. |
| b. Does the Veteran have anemia, including anemia caused by treatment for a hematologic or lymphatic condition?  | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled, Mandatory, Choose one valid valueElse; Enabled, Optional | [Yes; No] | N/A | Please answer the question: Does the Veteran have anemia, including anemia caused by treatment for a hematologic or lymphatic condition?  |
| (If “yes”, answer both questions 3.b.i and 3.b.ii) | If *Does the Veteran have anemia, including anemia caused by treatment for a hematologic or lymphatic condition? = Yes;* Enabled, Read-OnlyElse; Disabled | N/A | N/A | N/A |
| i. Is the anemia caused secondary to treatment of another hematologic or lymphatic condition? | If *Does the Veteran have anemia, including anemia caused by treatment for a hematologic or lymphatic condition?= Yes;* Enabled, MandatoryChoose one valid valueElse; Disabled | [Yes; No] | N/A | Please answer the question: Is the anemia caused secondary to treatment of another hematologic or lymphatic condition? |
| If yes, provide the name of the other condition: | If *Is the anemia caused secondary to treatment of another hematologic or lymphatic condition? = Yes;* Enabled, MandatoryElse; Disabled | N/A | Free Text | Please provide the name of the other hematologic or lymphatic condition that caused the secondary anemia. |
| ii. Is continuous medication required for control of the anemia? | If *Does the Veteran have anemia, including anemia caused by treatment for a hematologic or lymphatic condition?= Yes;* Enabled, MandatoryChoose one valid valueElse; Disabled | [Yes; No] | N/A | Please indicate whether or not continuous medication is required for control of the anemia. |
| If yes, list medication(s):  | If *Is continuous medication required for control of the anemia? = Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please list medication(s) continuously needed to control anemia. |
| c**.** Does the Veteran have thrombocytopenia, including thrombocytopenia caused by treatment for a hematologic or lymphatic condition?  | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled, Mandatory, Choose one valid valueElse; Enabled, Optional | [Yes; No] | N/A | Please answer the question: Does the Veteran have thrombocytopenia, including thrombocytopenia caused by treatment for a hematologic or lymphatic condition? |
| (If “yes”, answer both questions 3.c.i and 3.c.ii) | If *Does the Veteran have thrombocytopenia, including thrombocytopenia caused by treatment for a hematologic or lymphatic condition? = Yes;* Enabled, Read-OnlyElse; Disabled | N/A | N/A | N/A |
| i. Is the thrombocytopenia caused secondary to treatment of another hematologic or lymphatic condition? | If *Does the Veteran have thrombocytopenia, including thrombocytopenia caused by treatment for a hematologic or lymphatic condition?= Yes;* Enabled, MandatoryChoose one valid valueElse; Disabled | [Yes; No] | N/A | Please answer the question: Is the thrombocytopenia caused secondary to treatment of another hematologic or lymphatic condition? |
| If yes, provide the name of the other condition: | If *Is the thrombocytopenia caused secondary to treatment of another hematologic or lymphatic condition?= Yes;* Enabled, MandatoryElse; Disabled | N/A | Free Text | Please provide the name of the other hematologic or lymphatic condition that caused the secondary thrombocytopenia. |
| ii. Is continuous medication required for control of the thrombocytopenia? | If *Does the Veteran have thrombocytopenia, including thrombocytopenia caused by treatment for a hematologic or lymphatic condition?= Yes;* Enabled, MandatoryChoose one valid valueElse; Disabled | [Yes; No] | N/A | Please indicate whether or not continuous medication is required for control of the thrombocytopenia. |
| If yes, list medication(s):  | If *Is continuous medication required for control of the thrombocytopenia? = Yes;* Enabled, MandatoryElse; Disabled | N/A | Free Text | Please list medication(s) continuously needed to control thrombocytopenia. |

Figure 9: Template Example: DBQ – Hemic and Lymphatic – 3. Treatment



Figure 10: Print Example: DBQ – Hemic and Lymphatic – 3. Treatment

|  |
| --- |
|  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? |
|  [X] Yes [ ] No; watchful waiting |
|   |
|  If yes, indicate treatment type(s) (check all that apply): |
|  [ ] Treatment completed; currently in watchful waiting status |
|  [X] Bone marrow transplant |
|  If checked, provide: |
|  Date of hospital admission and location:  |
|  Date of hospital discharge after transplant:  |
|  [X] Surgery |
|  If checked, describe:  |
|  Date(s) of surgery:  |
|  [X] Radiation therapy |
|  Date of most recent treatment:  |
|  Date of completion of treatment or anticipated date of  |
|  completion:  |
|  [X] Antineoplastic chemotherapy |
|  Date of most recent treatment:  |
|  Date of completion of treatment or anticipated date of  |
|  completion:  |
|  [X] Other therapeutic procedure and/or treatment (describe):  |
|  Date of procedure:  |
|  Date of completion of treatment or anticipated date of  |
|  completion:  |
|   |
|  b. Does the Veteran have anemia, including anemia caused by treatment for a  |
|  hematologic or lymphatic condition? |
|  [X] Yes [ ] No (if "yes", answer both questions 3.b.i and 3.b.ii) |
|   |
|  i. Is the anemia caused secondary to treatment of another hematologic  |
|  or lymphatic condition? |
|  [X] Yes [ ] No |
|  If yes, provide the name of the other condition: |
|   |
|  ii. Is continuous medication required for control of the anemia? |
|  [X] Yes [ ] No |
|  If yes, list medication(s): |
|   |
|  c. Does the Veteran have thrombocytopenia, including thrombocytopenia caused  |
|  by treatment for a hematologic or lymphatic condition? |
|  [X] Yes [ ] No (if "yes", answer both questions 3.c.i and 3.c.ii) |
|   |
|  i. Is the thrombocytopenia caused secondary to treatment of another  |
|  hematologic or lymphatic condition? |
|  [X] Yes [ ] No |
|  If yes, provide the name of the other condition: |
|   |
|  ii. Is continuous medication required for control of the  |
|  thrombocytopenia? |
|  [X] Yes [ ] No |
|  If yes, list medication(s): |
|  |

## Section 4. Conditions, complications and/or residuals

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 5: Rules: DBQ – Hemic and Lymphatic – 4. Conditions, complications and/or residuals

| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| --- | --- | --- | --- | --- |
| **4. Conditions, complications and/or residuals** | Enabled, Read-Only | N/A | N/A | N/A |
| 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? | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled, Mandatory, Choose one valid valueElse; Enabled, Optional | [Yes; No] | N/A | Please answer the question: 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? |
| If yes, check all that apply: | If *previous question is Yes;* Enabled, Mandatory, Choose one or more valid valuesElse; Disabled | [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] | N/A | Please check at least one applicable condition, complication or residual. |
| If checked, indicate frequency: | If *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* = *Complications or residuals of treatment requiring transfusion of platelets or red blood cells*; Enabled, Mandatory, Choose one valid valueElse; Disabled | [ At least once per year but less than once every 3 months; At least once every 3 months; At least once every 6 weeks] | N/A | Please indicate the frequency that transfusion of platelets or red blood cells is required. |
| b. Does the Veteran currently have any other conditions, complications and/or residuals of treatment from a hematologic or lymphatic disorder? | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled, Mandatory,Choose one valid valueElse; Enabled, Optional | [Yes; No] | N/A | Please answer the question: Does the Veteran currently have any other conditions, complications and/or residuals of treatment from a hematologic or lymphatic disorder? |
| If yes, describe (brief summary): | If *previous question* = *Yes*; Enabled, MandatoryElse; Disabled | N/A | Free Text | Please describe any other conditions, complications and/or residuals. |

Figure 11: Template Example: DBQ – Hemic and Lymphatic – 4. Conditions, complications and/or residuals



Figure 12: Print Example: DBQ – Hemic and Lymphatic – 4. Conditions, complications and/or residuals

|  |
| --- |
|  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? |
|  [X] 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 |
|  [X] 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? |
|  [X] Yes [ ] No |
|   |
|  If yes, describe (brief summary):  |

## Section 5. Recurring infections

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 6: Rules: DBQ – Hemic and Lymphatic – 5. Recurring infections

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **5. Recurring infections** | Enabled, Read-Only | N/A | N/A | N/A |
| Does the Veteran currently have any conditions, complications and/or residuals of treatment for a hematologic or lymphatic disorder that result in recurring infections? | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled*,* Mandatory, Choose one valid valueElse; Enabled*,* Optional | [Yes; No] | N/A | Please answer the question: Does the Veteran currently have any conditions, complications and/or residuals of treatment for a hematologic or lymphatic disorder that result in recurring infections? |
| If yes, indicate frequency of infections: | If *previous question = Yes*; Enabled*,* Mandatory; Choose one valid valueElse; Disabled | [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] | N/A | Please indicate the frequency of infections. |

Figure 13: Template Example: DBQ – Hemic and Lymphatic – 5. Recurring infections



Figure 14: Print Example: DBQ – Hemic and Lymphatic – 5. Recurring infections

|  |
| --- |
| 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? |
| [X] Yes [ ] No |
|   |
|  If yes, indicate frequency of infections: |
|  [ ] Less than once per year |
|  [X] At least once per year but less than once every 3 months |
|  [ ] At least once every 3 months |
|  [ ] At least once every 6 weeks |

## Section 6. Thrombocytopenia (primary, idiopathic or immune)

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 7: Rules: DBQ – Hemic and Lymphatic – 6. Thrombocytopenia (primary, idiopathic or immune)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **6. Thrombocytopenia (primary, idiopathic or immune)** | If *Condition = thrombocytopenia*; Enabled*,*Read-OnlyElse; Disabled | N/A | N/A | N/A |
| Does the Veteran have thrombocytopenia? | If *Condition = thrombocytopenia*; Enabled*,* Mandatory, Choose one valid valueElse; Enabled*,* Optional | [Yes; No] | N/A | Please answer the question: Does the Veteran have thrombocytopenia? |
| If yes, check all that apply: | If *Does the Veteran have thrombocytopenia* = *Yes*; Enabled*,* Mandatory; Choose one or more valid valuesElse; Disabled | [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] | N/A | Please check all applicable statements regarding the Veteran's thrombocytopenia. |

Figure 15: Template Example: DBQ – Hemic and Lymphatic – 6. Thrombocytopenia (primary, idiopathic or immune)



Figure 16: Print Example: DBQ – Hemic and Lymphatic – 6. Thrombocytopenia (primary, idiopathic or immune)

|  |
| --- |
|  6. Thrombocytopenia (primary, idiopathic or immune) |
|  --------------------------------------------------- |
|  Does the Veteran have thrombocytopenia? |
|  [X] Yes [ ] No |
|   |
|  If yes, check all that apply: |
|  [ ] Stable platelet count of 100,000 or more |
|  [X] Stable platelet count between 70,000 and 100,000 |
|  [ ] Platelet count between 20,000 and 70,000 |
|  [ ] Platelet count of less than 20,000 |
|  [X] With active bleeding |
|  [X] Requiring treatment with medication |
|  [X] Requiring treatment with transfusions |
|   |

## Section 7. Polycythemia vera

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 8: Rules: DBQ – Hemic and Lymphatic – 7. Polycythemia vera

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **7. Polycythemia vera** | If *Condition = polycythemia vera;* Enabled, Read-OnlyElse; Disabled | N/A | N/A | N/A |
| Does the Veteran have polycythemia vera? | If *Condition = polycythemia vera;* Enabled*,* Mandatory, Choose one valid valueElse; Enabled*,* Optional | [Yes; No] | N/A | Please answer the question: Does the Veteran have polycythemia vera? |
| If yes, check all that apply: | If *Does the Veteran have polycythemia vera? = Yes*; Enabled*,* Mandatory; Choose one or more valid valuesElse; Disabled | [Stable, with or without continuous medication; Requiring phlebotomy;Requiring myelosuppressant treatment ] | N/A | Please check all applicable statements regarding the Veteran's polycythemia vera. |
| NOTE: If there are complications due to polycythemia vera such as hypertension, gout, stroke or thrombotic disease, also complete appropriate Questionnaire(s). | If *Does the Veteran have polycythemia vera? = Yes;* Enabled, Read-OnlyElse; Disabled | N/A | N/A | N/A |

Figure 17: Template Example: DBQ – Hemic and Lymphatic – 7. Polycythemia vera



Figure 18: Print Example: DBQ – Hemic and Lymphatic – 7. Polycythemia vera

|  |
| --- |
|  7. Polycythemia vera |
|  -------------------- |
|  Does the Veteran have polycythemia vera? |
|  [X] Yes [ ] No |
|   |
|  If yes, check all that apply: |
|  [X] Stable, with or without continuous medication |
|  [X] Requiring phlebotomy |
|  [X] 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). |
|  |

## Section 8. Sickle cell anemia

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 9: Rules: DBQ – Hemic and Lymphatic – 8. Sickle cell anemia

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **8. Sickle cell anemia**  | If *Condition = Sickle cell anemia*; Enabled, Read-OnlyElse; Disabled | N/A | N/A | N/A |
| Does the Veteran have sickle cell anemia? | If *Condition = Sickle cell anemia*; Enabled*,* Mandatory, Choose one valid valueElse; Disabled | [Yes; No] | N/A | Please answer the question: Does the Veteran have sickle cell anemia? |
| If yes, check all that apply: | If *Does the Veteran have sickle cell anemia?* = *Yes*; Enabled*,* MandatoryElse; Disabled | [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] | N/A | Please check all applicable statements regarding the Veteran's sickle cell anemia. |

Figure 19: Template Example: DBQ – Hemic and Lymphatic – 8. Sickle cell anemia



Figure 20: Print Example: DBQ – Hemic and Lymphatic – 8. Sickle cell anemia

|  |
| --- |
|  8. Sickle cell anemia |
|  --------------------- |
|  Does the Veteran have sickle cell anemia? |
|  [X] Yes [ ] No |
|   |
|  If yes, check all that apply: |
|  [ ] Asymptomatic |
|  [ ] In remission |
|  [X] With identifiable organ impairment |
|  [X] Following repeated hemolytic sickling crises with continuing  |
|  impairment of health |
|  [X] Painful crises several times a year |
|  [X] Repeated painful crises, occurring in skin, joints, bones or any  |
|  major organs |
|  [X] With anemia, thrombosis and infarction |
|  [ ] Symptoms preclude other than light manual labor |
|  [X] Symptoms preclude even light manual labor |

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

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 10: Rules: DBQ – Hemic and Lymphatic – 9. Other pertinent physical findings, complications, conditions, signs and/or symptoms

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **9. Other pertinent physical findings, complications, conditions, signs and/or symptoms** | Enabled, Read-Only | N/A | N/A | N/A |
| a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms? | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled*,* Mandatory, Choose one valid valueElse; Enabled*,* Optional | [Yes; No] | N/A | Please answer the question: Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms? |
| If yes, describe(brief summary): | If *Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms*= *Yes*; Enabled*,* MandatoryElse; Disabled | N/A | Free Text | Please describe any other pertinent physical findings, complications, conditions, signs and/or symptoms. |
| b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above? | If *Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms*= *Yes*; Enabled*,* MandatoryElse; Disabled | [Yes; No] | N/A | Please answer the question: Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section? |
| If yes, also complete a Scars Questionnaire for each scar. | Disabled; Read-Only | N/A | N/A | N/A |

Figure 21: Template Example: DBQ – Hemic and Lymphatic – 9. Other pertinent physical findings, complications, conditions, signs and/or symptoms



Figure 22: Print Example: DBQ – Hemic and Lymphatic – 9. Other pertinent physical findings, complications, conditions, signs and/or symptoms

|  |
| --- |
|  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? |
|  [X] Yes [ ] No |
|   |
|  If yes, describe (brief summary): Other pertinent findings will be  |
|  entered here  b. Does the Veteran have any scars (surgical or otherwise) related to any  conditions or to the treatment of any conditions listed in the Diagnosis  section above? [ ] Yes [ ] No  If yes, also complete a Scars Questionnaire for each scar. |

## Section 10. Diagnostic testing

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 11: Rules: DBQ – Hemic and Lymphatic – 10. Diagnostic testing

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **10. Diagnostic testing** | Enabled, Read-Only | N/A | N/A | N/A |
| 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: | Enabled, Read-Only | N/A | N/A | N/A |
| a. CBC: | Enabled*,* Optional | N/A | Free Text | N/A |
| Date: | If *CBC is populated*; Enabled*,* MandatoryElse; Enabled*,* Optional | N/A | Free Text | Please enter the date the CBC test was performed. |
| b. Hemoglobin level (gm/100ml): | Enabled*,* Optional | N/A | Free Text | N/A |
| Date: | If *Hemoglobin level is populated*; Enabled*,* MandatoryElse; Enabled*,* Optional | N/A | Free Text | Please enter the date the hemoglobin level test was performed. |
| c. Platelet count: | Enabled*,* Optional | N/A | Free Text | N/A |
| Date: | If *Platelet count is populated*; Enabled*,* MandatoryElse; Enabled*,* Optional | N/A | Free Text | Please enter the date the platelet count test was performed. |
| d. Are there any other significant diagnostic test findings and/or results? | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled*,* Mandatory, Choose one valid valueElse; Enabled*,* Optional | [Yes; No] | N/A | Please answer the question: Are there any other significant diagnostic test findings and/or results? |
| If yes, provide type of test or procedure, date and results (brief summary): | If *Are there any significant diagnostic test findings and/or results*= *Yes*; Enabled*,* MandatoryElse; Disabled | N/A | Free Text | Please provide the type of diagnostic test or procedure, the date and the results. |

Figure 23: Template Example: DBQ – Hemic and Lymphatic – 10. Diagnostic testing



Figure 24: Print Example: DBQ – Hemic and Lymphatic – 10. Diagnostic testing

|  |
| --- |
|  10. Diagnostic testing |
|  *----------------------* |
|  If testing has been performed and reflects Veteran's current condition, no further  |
|  testing is required. |
|   |
|  Provide most recent CBC, hemoglobin level or platelet count appropriate to the  |
|  Veteran's condition: |
|   |
|  a. CBC: Date:  |
|  |
|  b. Hemoglobin level (gm/100ml): Date:  |
|  |
|  c. Platelet count: Date:  |
|  |
|  d. Are there any other significant diagnostic test findings and/or results? |
|  [ ] Yes [ ] No |
|   |
|  If yes, provide type of test or procedure, date and results (brief  |
|  summary): |
|   |

## Section 11. Functional impact

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

Table 12: Rules: DBQ – Hemic and Lymphatic – 11. Functional impact

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **11. Functional Impact** | Enabled, Read-Only | N/A | N/A | N/A |
| Does the Veteran’s hematologic and/or lymphatic condition(s) impact his or her ability to work?  | If *Diagnosis = Yes* and *a condition is selected in the Diagnosis section*; Enabled*,* Mandatory, Choose one valid valueElse; Enabled*,* Optional | [Yes; No] | N/A | Please answer the question: Does the Veteran's hematologic and/or lymphatic condition(s) impact his or her ability to work? |
| If yes, describe impact of each of the Veteran’s hematologic and/or lymphatic conditions, providing one or more examples: | If *Does the Veteran’s hematologic and/or lymphatic condition(s) impact the Veteran’s ability to work* = *Yes*; Enabled*,* MandatoryElse; Disabled | N/A | Free Text | Please describe the impact of each hematologic and/or lymphatic condition on the Veteran's ability to work, providing one or more examples. |

Figure 25: Template Example: DBQ – Hemic and Lymphatic – 11. Functional impact



Figure 26: Print Example: DBQ – Hemic and Lymphatic – 11. Functional impact

|  |
| --- |
|  11. Functional impact |
|  --------------------- |
|  Does the Veteran's hematologic and/or lymphatic condition(s) impact his or  |
|  her ability to work? |
|  [X] Yes [ ] No |
|   |
|  If yes, describe impact of each of the Veteran's hematologic and/or  |
|  lymphatic conditions, providing one or more examples:  |
|  |
|   |

## Section 12. Remarks, if any

All questions in this section may be answered as described by the rules below.

Table 13: Rules: DBQ – Hemic and Lymphatic – 12. Remarks, if any

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field/Question** | **Field Disposition** | **Valid Values** | **Format** | **Error Message** |
| **12. Remarks, if any** | Enabled*,* Optional | N/A | Free Text | N/A  |

Figure 27: Template Example: DBQ – Hemic and Lymphatic – 12. Remarks, if any



Figure 28: Print Example: DBQ – Hemic and Lymphatic – 12. Remarks, if any

|  |
| --- |
|  12. Remarks, if any: |
|  -------------------- |

# Hemic and Lymphatic DBQ-AMIE Worksheet

The DBQ-AMIE worksheets are accessed via the Print Blank C&P Worksheet menu [DVBA C PRINT BLANK C&P WORKSHE] option.  Select the “DBQ HEMIC AND LYMPHATIC CONDITIONS INCLUDING LEUKEMIA” worksheet.   DBQ-AMIE worksheets should be sent to a printer.

 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page: 2

Disability Benefits Questionnaire for

Hematologic and Lymphatic Conditions

 Other diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If there are additional diagnoses that pertain to hematologic or lymphatic

 condition(s), list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Medical history

 a. Describe the history (including onset, course and status) of the

 Veteran's current condition(s) (brief summary):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 b. Indicate the status of the primary condition:

 \_\_\_ Active

 \_\_\_ Remission

 \_\_\_ Not applicable

 3. Treatment

 a. Has the Veteran completed any treatment or is the Veteran currently

 undergoing any treatment for any lymphatic or hematologic condition,

 including leukemia?

 \_\_\_ Yes \_\_\_ No; watchful waiting

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

 \_\_\_ Treatment completed; currently in watchful waiting status

 \_\_\_ Bone marrow transplant

 If checked, provide:

 Date of hospital admission and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of hospital discharge after transplant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Surgery

 If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date(s)of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Radiation therapy

 Date of most recent treatment: \_\_\_\_\_\_\_\_\_\_\_

 Date of completion of treatment or anticipated date of completion:\_\_\_\_

 \_\_\_ Antineoplastic chemotherapy

 Date of most recent treatment:\_\_\_\_\_\_\_\_\_\_\_\_

 Date of completion of treatment or anticipated date of

 completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Other therapeutic procedure and/or treatment (describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of procedure:\_\_\_\_\_\_\_\_\_\_\_

 Date of completion of treatment or anticipated date of

 completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page: 3

Disability Benefits Questionnaire for

Hematologic and Lymphatic Conditions

 b. Does the Veteran have anemia, including anemia caused by treatment for

 a hematologic or lymphatic condition?

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

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

 lymphatic condition?

 \_\_\_ Yes \_\_\_ No

 If yes, provide the name of the other condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 \_\_\_ Yes \_\_\_ No

 If yes, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 c. Does the Veteran have thrombocytopenia, including thrombocytopenia

 caused by treatment for a hematologic or lymphatic condition?

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

 i. Is the thrombocytopenia caused secondary to treatment of another

 hematologic or lymphatic condition?

 \_\_\_ Yes \_\_\_ No

 If yes, provide the name of the other condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 \_\_\_ Yes \_\_\_ No

 If yes, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Conditions, complications and/or residuals

 a. Does the Veteran currently have any conditions, complications and/or

 residuals due to a hematologic or lymphatic disorder or due to treatment

 for a hematologic or lymphatic disorder?

 \_\_\_ Yes \_\_\_ No

 If yes, check all that apply:

 \_\_\_ Weakness

 \_\_\_ Easy fatigability

 \_\_\_ Light-headedness

 \_\_\_ Shortness of breath

 \_\_\_ Headaches

 \_\_\_ Dyspnea on mild exertion

 \_\_\_ Dyspnea at rest

 \_\_\_ Tachycardia

 \_\_\_ Syncope

 \_\_\_ Cardiomegaly

 \_\_\_ High output congestive heart failure

 \_\_\_ Complications or residuals of treatment requiring transfusion of

 platelets or red blood cells

 If checked, indicate frequency:

 \_\_\_ At least once per year but less than once every 3 months

 \_\_\_ At least once every 3 months

 \_\_\_ At least once every 6 weeks

Page: 4

Disability Benefits Questionnaire for

Hematologic and Lymphatic Conditions

 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).

Page: 5

Disability Benefits Questionnaire for

Hematologic and Lymphatic Conditions

 8. Sickle cell anemia

 Does the Veteran have sickle cell anemia?

 \_\_\_ Yes \_\_\_ No

 If yes, check all that apply:

 \_\_\_ Asymptomatic

 \_\_\_ In remission

 \_\_\_ With identifiable organ impairment

 \_\_\_ Following repeated hemolytic sickling crises with continuing

 impairment of health

 \_\_\_ Painful crises several times a year

 \_\_\_ Repeated painful crises, occurring in skin, joints, bones or any

 major organs

 \_\_\_ With anemia, thrombosis and infarction

 \_\_\_ Symptoms preclude other than light manual labor

 \_\_\_ Symptoms preclude even light manual labor

 9. Other pertinent physical findings, complications, conditions, signs

 and/or symptoms

 a. Does the Veteran have any other pertinent physical findings,

 complications, conditions, signs and/or symptoms?

 \_\_\_ Yes \_\_\_ No

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

 b. Does the Veteran have any scars (surgical or otherwise) related to any

 conditions or to the treatment of any conditions listed in the Diagnosis

 section above?

 \_\_\_ Yes \_\_\_ No

 If yes, also complete a Scars Questionnaire for each scar.

 10. Diagnostic testing

 If testing has been performed and reflects Veteran's current condition, no

 further testing is required.

 Provide most recent CBC, hemoglobin level or platelet count appropriate to

 the Veteran's condition:

 a. CBC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 c. Platelet count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page: 6

Disability Benefits Questionnaire for

Hematologic and Lymphatic Conditions

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

 \_\_\_ Yes \_\_\_ No

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

 summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 11. Functional impact

 Does the Veteran's hematologic and/or lymphatic condition(s) impact his or

 her ability to work?

 \_\_\_ Yes \_\_\_ No

 If yes, describe impact of each of the Veteran's hematologic and/or

 lymphatic conditions, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 12. Remarks, if any:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_

 Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NOTE: VA may request additional medical information, including additional

 examinations if necessary to complete VA's review of the Veteran's

 application.