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Department of Veterans Affairs

RESPIRATORY CONDITIONS (OTHER THAN TUBERCULOSIS AND SLEEP APNEA) DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING THIS FORM.

NAME OF PATIENT/VETERAN *(First, Middle Initial, Last)*

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

___ – ___ – ____

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A RESPIRATORY CONDITION? *(This is the condition the veteran is claiming or for which an exam has been requested.)*

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the "Remarks" section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an appropriate date determined through record review or reported history.

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

☐ ASTHMA — ICD code: _____ Date of diagnosis: _____

☐ EMPHYSEMA — ICD code: _____ Date of diagnosis: _____

☐ CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) — ICD code: _____ Date of diagnosis: _____

☐ CHRONIC BRONCHITIS — ICD code: _____ Date of diagnosis: _____

☐ CONSTRICTIVE BRONCHIOLITIS — ICD code: _____ Date of diagnosis: _____

☐ INTERSTITIAL LUNG DISEASE *(If checked, specify):*

_____ ICD code: _____ Date of diagnosis: _____

NOTE - Interstitial lung diseases include but are not limited to asbestosis, diffuse interstitial fibrosis, interstitial pneumonitis, fibrosing alveolitis, desquamative interstitial pneumonitis, pulmonary alveolar proteinosis, eosinophilic granuloma of lung, drug-induced pulmonary pneumonitis and fibrosis, radiation-induced pulmonary pneumonitis and fibrosis, hypersensitivity pneumonitis (extrinsic allergic alveolitis) and pneumoconiosis such as silicosis, anthracosis, etc.)

☐ RESTRICTIVE LUNG DISEASE *(If checked, specify):*

_____ ICD code: _____ Date of diagnosis: _____

NOTE - Restrictive lung diseases include but are not limited to diaphragm paralysis or paresis, spinal cord injury with respiratory insufficiency, kyphoscoliosis, pectus excavatum, pectus carinatum, traumatic chest wall defect, pneumothorax, hernia, etc., post-surgical residual (lobectomy, pneumonectomy, etc.), chronic pleural effusion or fibrosis.

☐ SARCOIDOSIS — ICD code: _____ Date of diagnosis: _____

☐ BENIGN OR MALIGNANT NEOPLASM OR METASTASES OF RESPIRATORY SYSTEM *(If checked, specify):*

_____ ICD code: _____ Date of diagnosis: _____

☐ PULMONARY VASCULAR DISEASE *(Including pulmonary thromboembolism) (If checked, specify):*

_____ ICD code: _____ Date of diagnosis: _____

☐ OTHER DIAGNOSIS *(If checked, specify):*

_____ ICD code: _____ Date of diagnosis: _____

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO RESPIRATORY CONDITIONS, LIST USING ABOVE FORMAT:

NOTE - If diagnosed with Sleep Apnea complete VA Form 21-0960L-2, Sleep Apnea Disability Benefits Questionnaire. If diagnosed with Narcolepsy complete VA Form 21-0960C-6, Narcolepsy Disability Benefits Questionnaire.

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

☐ C-FILE (VA ONLY)

☐ OTHER, DESCRIBE: _____

SECTION III - MEDICAL HISTORY

3A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S RESPIRATORY CONDITION *(brief summary):*

3B. DOES THE VETERAN'S RESPIRATORY CONDITION REQUIRE THE USE OF ORAL OR PARENTERAL CORTICOSTEROID MEDICATIONS?

☐ YES ☐ NO *(If "Yes," complete the following):*

☐ Requires chronic low dose *(maintenance)* corticosteroids

☐ Requires intermittent courses or bursts of systemic *(oral or parenteral)* corticosteroids

(If checked, indicate number of courses or bursts in past 12 months):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Requires systemic *(oral or parenteral)* high dose *(therapeutic)* corticosteroids for control

☐ Requires daily use of systemic *(oral or parenteral)* high dose corticosteroids or immuno-suppressive medications

☐ Other, describe: _____

(If the veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for corticosteroids or immuno-suppressive medications): _____

3C. DOES THE VETERAN'S RESPIRATORY CONDITION REQUIRE THE USE OF INHALED MEDICATIONS?

☐ YES ☐ NO *(If, "Yes," check all that apply):*

☐ Inhalational bronchodilator therapy

(If "Yes," indicate frequency): ☐ Intermittent ☐ Daily

☐ Inhalational anti-inflammatory medication

(If "Yes," indicate frequency): ☐ Intermittent ☐ Daily

☐ Other inhaled medications, describe: _____

(If the veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for inhaled medications):

_____

3D. DOES THE VETERAN'S RESPIRATORY CONDITION REQUIRE THE USE OF ORAL BRONCHODILATORS?

☐ YES ☐ NO

(If "Yes," indicate frequency): ☐ Intermittent ☐ Daily

3E. DOES THE VETERAN'S RESPIRATORY CONDITION REQUIRE THE USE OF ANTIBIOTICS?

☐ YES ☐ NO

(If "Yes," list antibiotics, dose, frequency and condition for which antibiotics are prescribed): _____

3F. DOES THE VETERAN REQUIRE OUTPATIENT OXYGEN THERAPY FOR HIS OR HER RESPIRATORY CONDITION?

☐ YES ☐ NO

(If "Yes," does the veteran require continuous oxygen therapy (>17 hours/day?):

☐ YES ☐ NO

(If the veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the requirement for oxygen therapy):

_____

SECTION IV - PULMONARY CONDITIONS

4. DOES THE VETERAN HAVE ANY OF THE FOLLOWING PULMONARY CONDITIONS?

☐ YES ☐ NO *(If "No," proceed to Section V) (If "Yes," check all that apply):*

☐ Asthma	*(If checked, complete Part A below)*
☐ Bronchiectasis	*(If checked, complete Part B below)*
☐ Sarcoidosis	*(If checked, complete Part C below)*
☐ Pulmonary embolism and related diseases	*(If checked, complete Part D below)*
☐ Bacterial lung infection	*(If checked, complete Part E below)*
☐ Mycotic lung infection	*(If checked, complete Part F below)*
☐ Pneumothorax	*(If checked, complete Part G below)*
☐ Gunshot/fragment wound	*(If checked, complete Part H below)*
☐ Cardiopulmonary complications	*(If checked, complete Part I below)*
☐ Respiratory failure	*(If checked, complete Part J below)*
☐ Tumors or neoplasms	*(If checked, complete Part K below)*

☐ Other pulmonary conditions, pertinent physical findings or scars due to pulmonary conditions: _____

(If checked, complete Part I below)

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV - PULMONARY CONDITIONS *(Continued)*

PART A - ASTHMA

1. HAS THE VETERAN HAD ANY ASTHMA ATTACKS WITH EPISODES OF RESPIRATORY FAILURE IN THE PAST 12 MONTHS?

☐ YES ☐ NO *(If "Yes," indicate average number of asthma attacks with episodes of respiratory failure per week in past 12 months):*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

2. HAS THE VETERAN HAD ANY ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS?

☐ YES ☐ NO *(If "Yes," describe frequency and severity of exacerbations):* _____

(Indicate frequency of physician visits for required care of exacerbations over past 12 months): ☐ Less frequently than monthly ☐ At least monthly

PART B - BRONCHIECTASIS

1. INDICATE ANY FINDINGS, SIGNS AND SYMPTOMS THAT ARE ATTRIBUTABLE TO BRONCHIECTASIS:

☐ Productive cough *(If checked, indicate frequency and severity of productive cough (check all that apply)):*

- ☐ Intermittent
- ☐ Daily with purulent sputum at times
- ☐ Daily with blood-tinged sputum at times
- ☐ Near constant with purulent sputum
- ☐ Other, describe: _____

☐ Acute infection

(If checked, indicate number of infections requiring a prolonged course of antibiotics (lasting 4 to 6 weeks) in the past 12 months):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Requiring antibiotic usage almost continuously

☐ Anorexia *(If checked, describe):* _____

☐ Weight loss *(If checked, provide baseline weight:* _____ *and current weight:* _____ *)*

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

☐ Frank hemoptysis *(If checked, describe):* _____

☐ Other, describe: _____

2. HAS THE VETERAN HAD ANY INCAPACITATING EPISODES OF INFECTION DUE TO BRONCHIECTASIS?

*(**NOTE**: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician)*

☐ YES ☐ NO *(If "Yes," indicate total duration of incapacitating episodes of infection in past 12 months):*

- ☐ 0 to no more than 2 weeks
- ☐ 2 to no more than 4 weeks
- ☐ 4 to no more than 6 weeks
- ☐ At least 6 weeks or more

PART C - SARCOIDOSIS

1. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO SARCOIDOSIS?

☐ YES ☐ NO *(If, "Yes," check all that apply):*

- ☐ No physiologic impairment
- ☐ No symptoms
- ☐ Persistent symptoms *(If checked, describe):* _____
- ☐ Chronic hilar adenopathy
- ☐ Stable lung infiltrates
- ☐ Pulmonary involvement
- ☐ Progressive pulmonary disease *(If checked, describe):* _____
- ☐ Cardiac involvement with congestive heart failure
- ☐ Fever *(If checked, describe):* _____
- ☐ Night sweats *(If checked, describe):* _____
- ☐ Weight loss *(If checked, provide baseline weight:* _____ *and current weight:* _____ *)*

  *(**NOTE**: For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease)*
- ☐ Other, describe: _____

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

PART C - SARCOIDOSIS *(Continued)*

2. INDICATE STAGE DIAGNOSED BY X-RAY FINDINGS:

- ☐ Stage 1: Bihilar lymphadenopathy
- ☐ Stage 2: Bihilar lymphadenopathy and reticulonodular infiltrates
- ☐ Stage 3: Bilateral pulmonary infiltrates
- ☐ Stage 4: Fibrocystic sarcoidosis typically with upward hilar retraction, cystic and bullous changes

3. DOES THE VETERAN HAVE OPTHALMOLOGIC, RENAL, CARDIAC, NEUROLOGIC, OR OTHER ORGAN SYSTEM INVOLVEMENT DUE TO SARCOIDOSIS?

☐ YES ☐ NO *(If "Yes," also complete appropriate additional Questionnaires)*

PART D - PULMONARY EMBOLISM AND RELATED DISEASES

1. SELECT THE STATEMENT(S) THAT BEST DESCRIBE THE VETERAN'S PULMONARY VASCULAR DISEASE OR PULMONARY EMBOLISM CONDITION *(Check all that apply):*

- ☐ Asymptomatic, following resolution of pulmonary thromboembolism
- ☐ Symptomatic, following resolution of acute pulmonary embolism
- ☐ Chronic pulmonary thromboembolism requiring anticoagulant therapy
- ☐ Following inferior vena cava surgery
- ☐ Chronic pulmonary thromboembolism
- ☐ Pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins with evidence of right ventricular hypertrophy or cor pulmonale
- ☐ Other, describe: _____

PART E - BACTERIAL LUNG INFECTION

1. INDICATE CURRENT STATUS OF THE VETERAN'S BACTERIAL INFECTION OF THE LUNG *(including actinomycosis, nocardiosis and chronic lung abscess):*

☐ ACTIVE ☐ INACTIVE

2. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS AND SYMPTOMS ATTRIBUTABLE TO A BACTERIAL INFECTION OF THE LUNG OR CHRONIC LUNG ACCESS?

☐ YES ☐ NO *(If "Yes," check all that apply):*

- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss *(If checked, provide baseline weight:* _____ *and current weight:* _____ *)*

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

- ☐ Hemoptysis
- ☐ Other, describe: _____

PART F - MYCOTIC LUNG DISEASES

1. INDICATE STATUS OF MYCOTIC LUNG DISEASE *(including histoplasmosis of lung, coccidioidomycosis, blastomycosis, cryptococcosis, aspergillosis, or mucormycosis) (Check all that apply):*

- ☐ No symptoms
- ☐ Chronic pulmonary mycosis
- ☐ Healed and inactive mycotic lesions
- ☐ Occasional productive cough
- ☐ Occasional minor hemoptysis
- ☐ Requires suppressive therapy
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss *(If checked, provide baseline weight:* _____ *and current weight:* _____ *)*

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

- ☐ Massive hemoptysis
- ☐ Other, describe: _____

PART G - PNEUMOTHORAX

1. INDICATE THE TYPE OF PNEUMOTHORAX, TREATMENT AND RESIDUAL CONDITIONS, IF ANY *(Check all that apply):*

- ☐ Spontaneous total pneumothorax
- ☐ Spontaneous partial pneumothorax
- ☐ Traumatic total pneumothorax
- ☐ Traumatic partial pneumothorax
- ☐ Resulting in hospitalization *(If checked, provide date of hospital admission* _____ *and date of discharge* _____ *)*
- ☐ Resulting in residual conditions *(If checked, describe):* _____
- ☐ Other, describe: _____

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV - PULMONARY CONDITIONS *(Continued)*

PART H - GUNSHOT/FRAGMENT WOUND

1. SELECT THE STATEMENT(S) THAT BEST DESCRIBE THE VETERAN'S GUNSHOT OR FRAGMENT WOUND OR THE PLEURAL CAVITY AND RESIDUALS, IF ANY *(Check all that apply):*

- ☐ Bullet or missile retained in lung
- ☐ Pain or discomfort on exertion
- ☐ Scattered rales
- ☐ Some limitation of excursion of diaphragm or of lower chest expansion
- ☐ Other, describe: _____

*(**NOTE**: If any muscles (other than those which control respiration) are affected by this injury, ALSO complete VA Form 21-0960M-10, Muscle Injury Disability Benefits Questionnaire)*

PART I - CARDIOPULMONARY COMPLICATIONS

1. DOES THE VETERAN'S RESPIRATORY CONDITION RESULT IN CARDIOPULMONARY COMPLICATIONS SUCH AS COR PULMONALE, RIGHT VENTRICULAR HYPERTROPHY OR PULMONARY HYPERTENSION?

☐ YES ☐ NO *(If "Yes,"check all that apply):*

- ☐ Cor pulmonale *(right heart failure)*
- ☐ Right ventricular hypertrophy
- ☐ Pulmonary hypertension *(shown by echocardiogram or cardiac catheterization; report test results in Section 15, Diagnostic Testing)*
- ☐ Other, describe: _____

2. IF THE VETERAN HAS MORE THAN ONE RESPIRATORY CONDITION, INDICATE WHICH CONDITION IS PREDOMINANTLY RESPONSIBLE FOR THE EPISODES OF RESPIRATORY FAILURE:

PART J - RESPIRATORY FAILURE

1. PROVIDE DATES AND DESCRIBE THE VETERAN'S EPISODES OF ACUTE RESPIRATORY FAILURE:

2. IF THE VETERAN HAS MORE THAN ONE RESPIRATORY CONDITION, INDICATE WHICH CONDITION IS PREDOMINANTLY RESPONSIBLE FOR THE EPISODES OF RESPIRATORY FAILURE:

PART K - TUMORS AND NEOPLASMS

1. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," complete the following section)*

2. IS THE NEOPLASM:

☐ BENIGN ☐ MALIGNANT

3. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

☐ YES ☐ NO; WATCHFUL WAITING

(If, "Yes," indicate type of treatment (check all that apply)):

- ☐ Treatment completed; currently in watchful waiting status
- ☐ Surgery *(If checked, describe:* _____ *Date(s) of surgery:* _____ *)*
- ☐ Radiation therapy *(Date of most recent treatment:* _____ *Date of completion of treatment or anticipated date of completion:* _____ *)*
- ☐ Antineoplastic chemotherapy *(Date of most recent treatment:* _____
  Date of completion of treatment or anticipated date of completion: _____ *)*
- ☐ Other therapeutic procedure *(If checked, describe procedure):* _____
  (Date of most recent procedure): _____
- ☐ Other therapeutic treatment *(If checked, describe treatment):* _____
  (Date of completion of treatment or anticipated date of completion): _____

4. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM *(including metastases)* OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED?

☐ YES ☐ NO *(If "Yes," list residual conditions and complications (brief summary):*

5. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DESCRIBE USING THE ABOVE FORMAT:

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

PART L - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

1. 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?

☐ YES ☐ NO

IF "YES," ARE ANY OF THESE SCARS PAINFUL AND/OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM 6 square inches); OR ARE LOCATED ON THE HEAD, FACE, OR NECK?

☐ YES ☐ NO

IF "YES," ALSO COMPLETE VA FORM 21-0960F-1, *SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE (DBQ)*.

IF "NO," PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION:_____ MEASUREMENTS: Length_____ cm X width _____ cm.

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the "Remarks" section. It is not necessary to also complete a Scars/Disfigurement DBQ.

2. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," describe (brief summary):*

SECTION V - DIAGNOSTIC TESTING

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

5A. HAVE IMAGING STUDIES OR PROCEDURES BEEN PERFORMED? *(For VA purposes, imaging studies are not required for many respiratory conditions)*

☐ YES ☐ NO *(If "Yes," check all that apply):*

☐ Chest x-ray	Date: _____	Results: _____
☐ Magnetic resonance imaging *(MRI)*	Date: _____	Results: _____
☐ Computed tomography *(CT)*	Date: _____	Results: _____
☐ High resolution computed tomography to evaluate interstitial lung disease such as asbestosis *(HRCT)*	Date: _____	Results: _____
☐ Bronchoscopy	Date: _____	Results: _____
☐ Biopsy	Date: _____	Results: _____
☐ Other, describe: _____	Date: _____	Results: _____

5B. HAS PULMONARY FUNCTION TESTING (PFT) BEEN PERFORMED?

☐ YES ☐ NO

(If "Yes," do PFT results reported below reflect the veteran's current pulmonary function?)

☐ YES ☐ NO

MOST RESPIRATORY CONDITIONS REQUIRE PULMONARY FUNCTION TESTING, SINCE PFT RESULTS REPRESENT A MAJOR BASIS FOR THEIR EVALUATION. HOWEVER, PULMONARY FUNCTION TESTING IS NOT REQUIRED IN ALL INSTANCES. FOR VA PURPOSES, IF THE VETERAN HAS ANY OF THE FOLLOWING CONDITIONS, PFTs ARE NOT REQUIRED. IF PFTs HAVE NOT BEEN COMPLETED, INDICATE REASON:

☐ Veteran requires outpatient oxygen therapy
☐ Veteran has had 1 or more episodes of acute respiratory failure
☐ Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or hypertension
☐ Veteran has had exercise capacity testing and results are 20 ml/kg/min or less
☐ Other, describe: _____

5C. PFT RESULTS:

Date of test: _____

Pre-bronchodilator:	Post-bronchodilator, if indicated:
☐ FVC: _____ % predicted	☐ FVC: _____ % predicted
☐ FEV-1: _____ % predicted	☐ FEV-1: _____ % predicted
☐ FEV-1/FVC: _____ %	☐ FEV-1/FVC: _____ %
☐ DLCO: _____ % predicted	

5D. WHICH TEST RESULT MOST ACCURATELY REFLECTS THE VETERAN'S LEVEL OF DISABILITY *(Based on the condition that is being evaluated for this report)*? THIS QUESTION IS IMPORTANT FOR VA PURPOSES.

☐ FVC % predicted
☐ FEV-1 % predicted
☐ FEV-1/FVC
☐ DLCO

5E. IF POST-BRONCHODILATOR TESTING HAS NOT BEEN COMPLETED, INDICATE REASON:

☐ Pre-bronchodilator results are normal
☐ Not indicated for veteran's condition
☐ Not indicated in veteran's particular case *(If checked, provide reason):* _____
☐ Other, describe: _____

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION V - DIAGNOSTIC TESTING *(Continued)*

5F. IF DIFFUSION CAPACITY OF THE LUNG FOR CARBON MONOXIDE BY THE SINGLE BREATH METHOD (DLCO) TESTING HAS NOT BEEN COMPLETED, INDICATE REASON:

- ☐ Not indicated for veteran's condition
- ☐ Not indicated in veteran's particular case
- ☐ Not valid for veteran's particular case
- ☐ Other, describe: _____

5G. DOES THE VETERAN HAVE MULTIPLE RESPIRATORY CONDITIONS?

☐ YES ☐ NO

(If "Yes," list conditions and indicate which condition is predominantly responsible for the limitation in pulmonary function, if any limitation is present):

5H. HAS EXERCISE CAPACITY TESTING BEEN PERFORMED?

☐ YES ☐ NO *(If "Yes,"complete the following):*

- ☐ Maximum exercise capacity less than 15 ml/kg/min oxygen consumption *(with cardiac or respiratory limitation)*
- ☐ Maximum oxygen consumption of 15-20 ml/kg/min *(with cardiorespiratory limit)*

5I. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO *(If "Yes," describe (brief summary)):*

SECTION VI - FUNCTIONAL IMPACT

6. DOES THE VETERAN'S RESPIRATORY CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of each of the veteran's respiratory conditions, providing one or more examples):*

SECTION VII - REMARKS

7. REMARKS *(If any)*

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE/FAX NUMBERS	8E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	8F. PHYSICIAN'S ADDRESS

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

IMPORTANT - Physician please fax the completed form to: _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at **www.benefits.va.gov/disabilityexams** or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.