



**HAIRY CELL AND OTHER B-CELL LEUKEMIAS  
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 ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
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**NOTE TO PHYSICIAN** - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will use the information you provide on this questionnaire to process the Veteran's claim.

**SECTION I - DIAGNOSIS**

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH HAIRY CELL LEUKEMIA OR ANY OTHER B-CELL LEUKEMIA?  
 YES  NO (If "No," skip to Item 6, "Remarks")

**NOTE: Provide only diagnoses that pertain to hairy cell or any other B-cell leukemias**

1B. DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
1C. DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
1D. DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1E. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO HAIRY CELL AND OTHER B-CELL LEUKEMIAS, LIST USING ABOVE FORMAT

**SECTION II - STATUS OF DISEASE**

2. STATUS OF DISEASE  
 ACTIVE  REMISSION

**SECTION III - TREATMENT**

3. TREATMENT (Check one)  
 VETERAN IS CURRENTLY UNDERGOING TREATMENT FOR THIS LEUKEMIA WITH SURGICAL, RADIATION, IMMUNOTHERAPY, ANTINEOPLASTIC CHEMOTHERAPY AND/OR OTHER THERAPEUTIC PROCEDURES  
 VETERAN HAS COMPLETED TREATMENT FOR THIS LEUKEMIA - Date of discontinuance of treatment: \_\_\_\_\_

**SECTION IV - COMPLICATIONS OR RESIDUALS OF TREATMENT**

4A. DOES THE VETERAN CURRENTLY HAVE ANY COMPLICATIONS OR RESIDUALS OF TREATMENT?  YES  NO  
 (Check all that apply)

4B. ARE THERE ANY COMPLICATIONS OR RESIDUALS REQUIRING TRANSFUSION OF PLATELETS OR RED CELLS?  
 YES  NO (If "Yes," 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

4C. ARE THERE ANY COMPLICATIONS OR RESIDUALS CAUSING RECURRING INFECTIONS?  
 YES  NO (If "Yes," 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

4D. ARE THERE ANY COMPLICATIONS OR RESIDUALS RELATED TO ANEMIA?

YES  NO (If "Yes," check all that apply)  
 ASYMPTOMATIC ANEMIA  
 REQUIRES CONTINUOUS MEDICATION  
 REQUIRES BONE MARROW TRANSPLANT - Date: \_\_\_\_\_  
 SYMPTOMATIC ANEMIA (Check signs and symptoms that apply)  
 WEAKNESS  EASY FATIGABILITY  DYSPNEA ON MILD EXERTION  
 LIGHT-HEADEDNESS  SHORTNESS OF BREATH  SYNCOPE  
 CARDIOMEGALY  TACHYCARDIA  DYSPNEA AT REST  
 HIGH OUTPUT CONGESTIVE HEART FAILURE  HEADACHES  OTHER SYMPTOM(S) (Specify \_\_\_\_\_)

IF AVAILABLE, PROVIDE MOST RECENT HEMOGLOBIN LEVEL (gm/100ml): \_\_\_\_\_ Date \_\_\_\_\_

IF AVAILABLE, PROVIDE MOST RECENT PLATELET COUNT: \_\_\_\_\_ Date \_\_\_\_\_

4E. IF ANY OTHER RESIDUAL COMPLICATIONS ARE PRESENT PLEASE SPECIFY:

**SECTION V - FUNCTIONAL IMPACT AND REMARKS**

5. DOES THE VETERAN'S B-CELL LEUKEMIA IMPACT THE VETERAN'S ABILITY TO WORK?

YES     NO    *(If "Yes," describe impact, providing one or more examples)*

6. REMARKS *(If any)*

**SECTION VI - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

7A. PHYSICIAN'S SIGNATURE		7B. PHYSICIAN'S PRINTED NAME	7C. DATE SIGNED
7D. PHYSICIAN'S PHONE NUMBER	7E. PHYSICIAN'S MEDICAL LICENSE NUMBER	7F. PHYSICIAN'S ADDRESS	

**NOTE** - VA may obtain additional medical information, including an examination, 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.vba.va.gov/disabilityexams](http://www.vba.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, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

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