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OVERVIEW:
INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS, CHRONIC FATIGUE SYNDROME, OR TUBERCULOSIS) DISABILITY BENEFITS QUESTIONNAIRE
*** Including COVID-19 ***

***REMINDER:** Review Claimant and Provider Exam forms for case specific instructions ***

History	Physical Exam	Diagnostics/Diagnosis
Obtain detailed history: ▪ **Date of onset:** ➢ Describe when and how the condition began. ▪ **Describe course:** ➢ Has the condition gotten better, stayed the same, worsened? ▪ **Symptoms:** ➢ Initial symptoms ➢ Current symptoms ▪ **Treatment:** ➢ Document medication, surgery, and/or other types of treatment ➢ Indicate response to medication and/or treatment **Medical Record Review:** ▪ Required for all cases-mark VA e-folder was reviewed ▪ For routine medical opinions or MEB referred conditions, examiner must provide a brief list of records reviewed to include date, location, author, diagnoses and/or other pertinent findings in the "evidence comments" section. ▪ Look for evidence of: ▪ Confirmed COVID-19, if any ▪ Complaints of or treatment for COVID-19 symptoms	**Physical Examination** ▪ Document/indicate whether examinee has or has ever been diagnosed with an infectious condition: ➢ Indicate state of each infectious disease (active or inactive) ○ If ***INACTIVE***: indicate date condition became inactive ○ If ***ACTIVE***: indicate date of cessation of treatment ➢ Indicate if there are current symptoms related/due to the infectious disease(s); if YES, describe all symptoms related to it ➢ Indicate if there are residuals related/due to the infectious disease **NOTE:** If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability due to the infectious disease diagnosis **Other Pertinent findings:** ▪ Scars ➢ Document only those scars related to the diagnosed infectious disease(s) ➢ Measure length and width in cm ➢ If scar is painful or unstable or has a total area equal to or greater than 39 square cm (6 square inches), complete scar exam form	**Diagnostics**: ▪ VA requires diagnostic confirmation for both the initial diagnosis and any relapse or recurrence. Certain infectious diseases require specific testing methods to confirm recurrence of active infection. (See Diagnostic Guidance on pg.2) ▪ **EXCEPTION**: COVID-19 contentions do not require any testing. Refer to Special instructions for any confirmed testing made available by VA, if any. For COVID-19 contentions 5a-5D may be reported blank. Complete 5E regarding results, if available **OR** to discuss procurable evidence available to support a diagnosis ▪ If additional diagnostics are needed for evaluation purposes, call QTC Provider support at 1-844-782-7783 while examinee is still in the office **Diagnosis**: ▪ Diagnoses must be *definitive* ▪ ICD 10 code required ▪ Date of diagnosis should be date of exam or taken from history/records ❖ ***Claimed condition*:** Has not been recognized by VA for compensation purposes. Determine if there is a diagnosis based on VA guidelines/criteria ❖ ***Established Diagnosis:*** Already conceded as service connected, any change made should be explained ❖ ***MEB referred:*** Typically, diagnosis and/or treatment is well documented in medical records. It should be treated like an established diagnosis. Non-diagnosis is discouraged, and any changes should be explained **Functional Impact:** ▪ Comment on how the infectious disease(s) impacts the examinee's ability to work regardless of employment status. **Remarks:** ▪ Document life-threatening findings and indicate if claimant was notified to follow up with PCP. ▪ Indicate if examinee is homeless ▪ Document any suicidal ideation

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DIAGNOSTIC GUIDANCE

*** If testing has been performed and reflects Veteran's current condition, repeat testing is not required.***

NOTE: For VA purposes, **relapse** is defined as a full return of a disease or the signs and symptoms of a disease after a period of improvement and **recurrence** refers to another separate disease episode after a full recovery has been attained

INFECTIOUS DISEASE DIAGNOSIS		DOCUMENTATION
Visceral Leishmaniasis Miliary Tuberculosis Nontuberculosis Mycobacterium Infection	State if the recurrence of active infection is confirmed by either of the following: • Culture • Histopathlogy • Other laboratory testing	1. **INDICATE TEST/PROCEDURE** which confirmed infection 2. INDICATE **DATE** OF TEST/PROCEDURE 3. **BRIEF SUMMARY** OF RESULTS
Malaria	State if the initial diagnosis or relapse is confirmed by: • Identification of the malarial parasites in blood smears • Identification of the malarial parasites in other specific diagnostic laboratory tests, such as antigen detection, immunologic (immunochromatographic) tests, or molecular testing such as polymerase chain reaction tests	
Brucellosis	State if the initial diagnosis or recurrence of active infection is confirmed by: • Culture • Serologic testing	
Meloidosis	State if the initial diagnosis and any relapse or chronic activity of infection is confirmed by • Culture • Other specific diagnostic laboratory tests	
ALL other infectious Diagnoses	For initial diagnosis, relapse, or recurrence, state the way in which active infection is confirmed	
SARs-CoV-2 or COVID-19	For initial diagnosis, relapse, or recurrence, state the way in which active infection is confirmed	**FOR COVID-19** 1. **INDICATE TEST/PROCEDURE** which confirmed infection 2. INDICATE **DATE** OF TEST/PROCEDURE 3. **BRIEF SUMMARY** OF RESULTS *Only if available **OR** discuss procurable evidence available to support a diagnosis*