OMB Approved No. 2900-0781
Respondent Burden: 15 minutes

Department of Veterans Affairs

NARCOLEPSY 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 FORM.

NAME OF PATIENT/VETERAN	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.

SECTION I - DIAGNOSIS

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

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

1B. DIAGNOSES *(check all that apply):*

☐ NARCOLEPSY ICD code: _____ Date of diagnosis: _____

☐ OTHER *(specify):*

Other diagnosis #1: _____ ICD code: _____ Date of diagnosis: _____

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

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 NARCOLEPSY *(brief summary)*:

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF NARCOLEPSY?

☐ YES ☐ NO *(If "Yes," list only those medications required for the veteran's narcolepsy):*

SECTION IV- FINDINGS, SIGNS AND SYMPTOMS

4A. DOES THE VETERAN HAVE A CONFIRMED DIAGNOSIS OF NARCOLEPSY?

☐ YES ☐ NO *(If "Yes," complete Items 4A & 4B)*

4B. DOES THE VETERAN REPORT ANY OF THE FOLLOWING FINDINGS, SIGNS OR SYMPTOMS?

☐ YES ☐ NO

(If "Yes," check all that apply):

☐ Excessive daytime sleepiness

☐ Sleep attacks *(strong urge to sleep followed by short nap)*

☐ Cataplexy *(sudden loss of muscle tone while awake, resulting in brief inability to move)*

☐ Sleep paralysis *(inability to move on first awakening)*

☐ Sleep onset/sleep offset hallucinations

☐ Other

(For all checked conditions in item 4B, provide a description below):

4C. INDICATE FREQUENCY OF CATAPLECTIC (NARCOLEPTIC) EPISODES *(check all that apply):*

Number of cataplectic (narcoleptic) episodes over past 6 months

☐ 0-1

☐ 2 or more

(If 2 or more over the past 6 months, indicate the "average frequency" of narcoleptic episodes):

☐ 0-4 per week ☐ 5-8 per week ☐ 9-10 per week ☐ More than 10 per week

(If the Veteran has cataplectic (narcoleptic) episodes, provide a description below):

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

5. 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 VI - DIAGNOSTIC TESTING

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

6A. HAVE ANY IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED?

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

☐ Polysomnogram *(PSG)*	Date: _____	Results: _____
☐ Multiple Sleep Latency Test *(MSLT)*	Date: _____	Results: _____
☐ Hypocretin level in cerebrospinal fluid *(CSF)*	Date: _____	Results: _____
☐ Other *(describe):* _____	Date: _____	Results: _____

6B. 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 VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S NARCOLEPSY IMPACT HIS OR HER ABILITY TO WORK?

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

SECTION VIII - REMARKS

8. REMARKS *(If any):*

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBERS	9E. PHYSICIAN'S MEDICAL LICENSE NUMBER	9F. 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.