WOMEN'S INTERAGENCY HIV STUDY

QUESTION BY QUESTION SPECIFICATIONS

FORM HOSP: HOSPITALIZATION FORM

General Instructions:

1. All dates should be recorded in the MM/DD/YY format unless otherwise noted. For dates that must be completed on the form, if the participant cannot remember the exact month (and day), probe for the season. Use *"15"* for the day if the specific day cannot be recorded. Probe for the season and assign the month as follows:

Summer	=	July	=	07
Fall	=	October	=	10
Winter	=	January	=	01
Spring	=	April	=	04

   Interviewers should have available an appropriate calendar to aid the participant in determining dates. Years in response to questions inquiring about occurrences "since last visit" should be 1995 and thereafter.

2. Times should be recorded in the HH:MM format. Remember to use leading zeros, e.g., 08:00.

3. For questions containing an open-ended specify box linked to the response "other," interviewers should print responses exactly in the words of the respondent.

SECTION A: GENERAL INFORMATION

A7. If form is being administered at a **core visit**, circle "1" and proceed to Question A8. If form is being administered as part of **site-initiated interim contact** (e.g., phone call from site to participant), circle "2" and skip to Section C of the form. If form is being administered during **participant-initiated interim contact** (e.g., phone call from participant to site), circle "3" and skip to Section C of the form.

A8. Ask this question of all women attending a core visit. Any hospital admission or emergency room (ER) visit should result in a response of "YES." **Do not include urgent care visits.** If response is "NO," skip to Question D1 and end form.

A9. Record what the participant indicates is/are the reason(s) for her hospitalization(s). "YES" may be circled for more than one response. If the participant answers "other," record her answer verbatim in the space provided.

A10. Record the number of times the participant reports she has been hospitalized or visited the ER since her (MONTH) study visit. Proceed to Section B.

SECTION B: HOSPITALIZATIONS REPORTED AT CORE VISIT

READ INTRODUCTION.

B1. Enter the date of the (first, second, etc.) visit the participant made to the hospital or ER.

B2. Ask the participant for the **main reason** she visited the hospital or ER on this date. Do not read the response options to the participant, but rather listen to the reason in her words, and circle the appropriate choice from the form. If the reason doesn't fit one of the response categories "1" through "9," then circle "10" for "other reason," and specify the reason in Question B2a.

B3. Ask Question B3 to determine whether the visit was to the ER only, was a hospital admission only, or was a visit to the ER that resulted in admission to the hospital.

- If **ER visit only**, then circle "1" for Question B3a, and "2" for Question B3b.
- If **hospital admission only**, then circle "2" for Question B3a, and "1" for Question B3b.
- If **ER visit that resulted in being admitted to the hospital**, then circle "1" for Questions B3a and B3b.
- If participant is **unsure**, then enter "-8" for Question B3a, and "1" for Question B3b.

NOTE: A "YES" response to Question B3b will generate an ATC record with disease code 300 (hospitalization). Ascertainment Tracking Checklist (ATC) should be completed for each hospital admission reported in Section B. ATC need not be completed for ER-only visits.

PROMPT: IF PARTICIPANT REPORTS MORE THAN ONE HOSPITALIZATION OR ER VISIT, COMPLETE SECTION B ONCE FOR EACH HOSPITALIZATION OR ER VISIT. USE A BLANK VERSION OF SECTION B FOR EACH HOPSITALIZATION OR ER VISIT. AFTER SECTION B IS COMPLETED FOR EVERY HOSPITALIZATION OR ER VISIT, GO TO QUESTION B4 AND ENTER "1."

B4. This question is on the form for programming purposes only. Circle "1" and skip to Question D1.

SECTION C: HOSPITALIZATIONS REPORTED DURING SITE- or PARTICIPANT-INITIATED INTERIM CONTACT

READ APPROPRIATE INTRODUCTION.

- If form is being completed via **site-initiated** interim contact, read "INTRO #1." After reading "INTRO #1," skip to Question C1.
- If form is being completed via **participant-initiated** interim contact, skip "INTRO #1" and read "INTRO #2." After reading "INTRO #2," proceed to Question C1.

C1. Record the number of times the participant reports she has been **admitted** to the hospital since her last contact with the study site. Last contact might be since her last core visit, or might be since her last phone call to/from the clinic to report a hospitalization. **Do not record ER or urgent care visits in this question; only hospital admissions should be reported.** If participant reports zero (0) hospitalizations, skip to Question D1 and end form.

C2. Enter the date of the (first, second, etc.) visit the participant made to the hospital.

C3. Ask the participant for the **main reason** she visited the hospital on this date. Do not read the response options to the participant, but rather listen to the reason in her words, and circle the appropriate choice from the form. If the reason doesn't fit one of the response categories "1" through "9," then circle "10" for "other reason," and specify the reason in Question C3a.

C4. This question is on the form for programming purposes only. Circle "1" for "HOSPITAL ADMISSION."

NOTE: A "YES" response to Question C4 will generate an ATC record with disease code 300 (hospitalization). Ascertainment Tracking Checklist (ATC) should be completed for each hospital admission reported in Section C.

PROMPT: IF PARTICIPANT REPORTS MORE THAN ONE HOSPITALIZATION, COMPLETE SECTION C ONCE FOR EACH HOSPITALIZATION. USE A BLANK VERSION OF SECTION C FOR EACH HOSPITALIZATION .

D1. Record the time module was completed**.**