WOMEN'S INTERAGENCY HIV STUDY

ABBREVIATED VISIT ABSTRACT TRACKING CHECKLIST

FORM ABRV ATC

SECTION A: GENERAL INFORMATION

A1. WIHS ID NUMBER: |__| - |__|__| - |__|__|__|__| - |__|

A2. WIHS STUDY VISIT #: ____ ____

A3. FORM VERSION: 0 8 / 0 1 / 9 7

A4. DATE OF INTERVIEW: ___ ___ / ___ ___ / ___ ___
M D Y

A5. INTERVIEWER'S INITIALS: ____ ____ ____

A6. DATE OF LAST STUDY VISIT: ___ ___ / ___ ___ / ___ ___
(FROM VISIT CONTROL SHEET) M D Y

A7. DOES WIHS SITE HAVE THE PARTICIPANT'S SIGNED MEDICAL RECORD RELEASE?

YES..... 1
NO..... 2

PROMPT: ABSTRACTION CANNOT BE PERFORMED UNTIL THE PARTICIPANT HAS SIGNED AND RETURNED THE MEDICAL RECORD RELEASE FORM TO THE SITE. IF INTERVIEW WAS CONDUCTED BY TELEPHONE AND MEDICAL RECORD RELEASE WAS NOT GIVEN TO THE PARTICIPANT IN PERSON, THEN A MEDICAL RECORD RELEASE FORM SHOULD BE MAILED TO THE PARTICPANT WITH A SELF ADDRESSED STAMPED ENVELOPE AND FOLLOWED UP WITH A REMINDER PHONE CALL.

SECTION B: INFORMATION TO ABSTRACT

INSTRUCTIONS: USE THIS FORM AS A CHECKLIST DURING ADMINISTRATION OF THE ABBREVIATED INTERVIEW. AFTER COMPLETING THE INTERVIEW, REVIEW CHECKLIST WITH PARTICIPANT TO OBTAIN INFORMATION IN COLUMNS b AND c (DATES, PROVIDER AND INSTITUTION NAMES AND ADDRESSES).

a. QUESTION NUMBER	b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
☐ B4 - PCP Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____ _____
☐ B5 - Other Pneumonia Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____ _____

a. QUESTION NUMBER	b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
☐ B6 - Cancer _____ **(SPECIFY)** Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____
☐ B7 - TB Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____
☐ B8 - Candida Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____
☐ B9 - MAC/MAI Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____
☐ B10 - Wasting Syndrome Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____
☐ B11 - CMV Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____
☐ B12 - Shingles Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____
☐ B13 - AIDS Inpatient:_____ Outpatient: ____	___ ___ / ___ ___ / ___ ___ M D Y	_____

B14. # of Hospitalizations: _____

a. QUESTION NUMBER	b. DATE OF EVENT SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
☐ B14i - Hospitalization (1)	___ ___ / ___ ___ / ___ ___ (M D Y)	
☐ B14ii - Hospitalization (2)	___ ___ / ___ ___ / ___ ___ (M D Y)	
☐ B14iii - Hospitalization (3)	___ ___ / ___ ___ / ___ ___ (M D Y)	
☐ B14iv - Hospitalization (4)	___ ___ / ___ ___ / ___ ___ (M D Y)	
☐ B14v - Hospitalization (5)	___ ___ / ___ ___ / ___ ___ (M D Y)	

a. QUESTION NUMBER	b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
☐ B15a.iv - PID	___ ___ / ___ ___ / ___ ___ (M D Y)	
☐ B15a.ix - Yeast vaginitis or candida	___ ___ / ___ ___ / ___ ___ (M D Y)	