LABORATORY - PELVIC EXAM STUDIES
TREATMENT FORM

FORM L16

ID LABEL HERE ---> |__| - |__|__| - |__|__|__|__| - |__|

VISIT #: ___ ___

FORM COMPLETED BY: ___ ___ ___

VERSION DATE: **05/01/95**

ANY MISSING OR INCOMPLETE TEST RESULTS MUST BE EXPLAINED ON THIS FORM.

A1. DATE OF PROCEDURE: ___ ___ / ___ ___ / ___ ___
M D Y

A2. FIRST TREATMENT:

YES ..... 1 **(A5)**
NO 2

A3. REPEATED TREATMENT:

YES ..... 1 **(a)**
NO ..... 2 **(A5)**

a. total # of treatments |__|__|
(not including this one)

A4. DATES OF PRIOR TREATMENTS: METHOD OF TREATMENT:

___ ___ / ___ ___ / ___ ___ _____
M D Y **(SPECIFY)**

___ ___ / ___ ___ / ___ ___ _____
M D Y **(SPECIFY)**

___ ___ / ___ ___ / ___ ___ _____
M D Y **(SPECIFY)**

WIHS ID #

A5. INDICATION FOR TREATMENT (Circle the most severe lesion for each)

a. Cervical

None 1
Exophytic condyloma..... 2
LG SIL: HPV..... 3
LG SIL: CIN1 (Mild dysplasia)..... 4
LG SIL: Unspecified 5
HG SIL: CIN II (Mod dysplasia) 6
HG SIL: CIN III (Severe/CIS)..... 7
Microinvasive CA..... 8
Invasive CA 9
Adenocarcinoma - in - situ 10
Adenocarcinoma 11
Other..... 12

_____
(SPECIFY)

b. Vaginal

None 1
HPV lesion..... 2
VAIN I..... 3
VAIN II..... 4
VAIN III..... 5
Invasive CA 6
Other..... 7

_____
(SPECIFY)

c. Vulvar

None 1
HPV lesion..... 2
VIN I..... 3
VIN II..... 4
VIN III..... 5
Invasive CA 6
Other..... 7

_____
(SPECIFY)

d. Perianal

None 1
HPV lesion..... 2
PAIN I..... 3
PAIN II 4
PAIN III 5
Invasive CA 6
Other..... 7

_____
(SPECIFY)

WIHS ID #

e. Anal

None 1
HPV lesion..... 2
AIN I..... 3
AIN II..... 4
AIN III..... 5
Invasive CA 6
Other..... 7

_____

(SPECIFY)

f. Endometrium

None 1
Atypical hyperplasia..... 2
Invasive CA 3
Other..... 4

_____

(SPECIFY)

g. Other Location:

Yes..... 1
No..... 2(**A6)**

i. Location

_____

(SPECIFY)

ii. Lesion

_____

(SPECIFY)

A6. INDICATION FOR TREATMENT BASED ON:
(circle yes or no for each indication)

		YES	NO
a.	Suspicious pap smear with inadequate colposcopy.....	1	2
b.	Histologic diagnosis	1	2
c.	Pap smear - histologic - colposcopic discrepancy	1	2
d.	Abnormal colposcopy.....	1	2
e.	Grossly apparent lesion.....	1	2
f.	Other.....	1	2

_____

(SPECIFY)

WIHS ID #

A7. TREATMENT MODALITY:

a. Cervix **(circle yes or no for each modality)**

	YES	NO
1. None/Observation	1 **(b)**	2
2. Interferon	1	2
3. 5 - FU	1	2
4. Cryotherapy	1	2
5. Laser vaporization	1	2
6. Laser conization	1	2
7. LEEP/LLETZ (transformation zone)	1	2
8. LEEP conization	1	2
9. Cold - knife conization	1	2
10. Hysterectomy (simple)	1	2
11. Hysterectomy (radical)	1	2
12. Radiation therapy	1	2
13. Other	1	2

_____

(SPECIFY)

b. Vagina **(circle yes or no for each modality)**

	YES	NO
1. None/Observation	1 **(c)**	2
2. TCA	1	2
3. Podophyllin	1	2
4. Condylox	1	2
5. Interferon	1	2
6. 5 - FU	1	2
7. Cryotherapy	1	2
8. Laser vaporization	1	2
9. LEEP	1	2
10. Vaginal excision (local)	1	2
11. Vaginectomy	1	2
12. Radiation therapy	1	2
13. Other	1	2

_____

(SPECIFY)

WIHS ID #

c. Vulva **(circle yes or no for each modality)**

		YES	NO
1.	None/Observation	1 **(d)**	2
2.	TCA	1	2
3.	Podophyllin	1	2
4.	Condylox	1	2
5.	Interferon	1	2
6.	5 - FU	1	2
7.	Cryotherapy	1	2
8.	Laser vaporization	1	2
9.	LEEP	1	2
10.	Wide local excision	1	2
11.	Vulvectomy	1	2
12.	Radiation therapy	1	2
13.	Other	1	2

_____

(SPECIFY)

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d. Perianal **(circle yes or no for each modality)**

		YES	NO
1.	None/Observation	1 **(e)**	2
2.	TCA	1	2
3.	Podophyllin	1	2
4.	Condylox	1	2
5.	Interferon	1	2
6.	5 - FU	1	2
7.	Cryotherapy	1	2
8.	Laser vaporization	1	2
9.	LEEP	1	2
10.	Excision	1	2
11.	Radiation therapy	1	2
12.	Other	1	2

_____

(SPECIFY)

WIHS ID #

e. Anal **(circle yes or no for each modality)**

		YES	NO
1.	None/Observation	1 **(f)**	2
2.	TCA	1	2
3.	Podophyllin	1	2
4.	Condylox	1	2
5.	Interferon	1	2
6.	5 - FU	1	2
7.	Cryotherapy	1	2
8.	Laser vaporization	1	2
9.	LEEP	1	2
10.	Excision	1	2
11.	Radiation therapy	1	2
12.	Other	1	2

_____

(SPECIFY)

f. Endometrium **(circle yes or no for each modality)**

		YES	NO
1.	None/Observation	1 **(g)**	2
2.	Hormone therapy	1	2
3.	Dilation and Curettage (D&C)	1	2
4.	Hysterectomy (simple)	1	2
5.	Hysterectomy (radical)	1	2
6.	Radiation therapy	1	2
7.	Other	1	2

_____

(SPECIFY)

g. Other Location:

Yes.....1
No.....2(**A8)**

i. Location:

_____

(SPECIFY)

ii. Modality

_____

(SPECIFY)

WIHS ID #

A8. IS THIS PATIENT PART OF ANOTHER STUDY EVALUATION FOR TREATMENT OF DYSPLASIA?

YES 1
NO .....2 **(A9)**

a. SPECIFY NAME OF STUDY:_____

b. SPECIFY NAME OF STUDY SITE: _____

A9. WAS HISTOLOGIC EVALUATION OBTAINED OR BIOPSY PERFORMED DURING THIS TREATMENT PROCEDURE ?

YES .....1 **(Complete Form L15 for each biopsy performed)**
NO 2

A10. FOLLOW UP SCHEDULED?

YES 1
NO .....2 **(A11)**
UNKNOWN.....<-8> **(A11)**

a. INDICATE SCHEDULED FOLLOW-UP IN WEEKS OR MONTHS:

|__|__| WEEKS 1
MONTHS..... 2

b. INDICATE TYPE OF FOLLOW-UP PLANNED:

Repeat pap only 1
Repeat pap & colposcopy.....2
Repeat colposcopy only 3
Repeat treatment 4
Other 5

_____
(SPECIFY)

A11. WAS TREATMENT COMPLETED TODAY?

YES, Complete 1
NO, Incomplete.....2
Ongoing 3
Delayed 4
Other 5

_____
(SPECIFY)
Refused .....<-7>
Unknown .....<-8>

WIHS ID #

A12. HOW WAS THIS INFORMATION OBTAINED?
(circle yes or no for each source)

	YES	NO
a. Study personnel	1	2
b. Chart abstraction	1	2
c. Direct contact with provider	1	2
d. Patient history	1	2
e. Other	1	2

_____
(SPECIFY)

A13. INDICATE PRIMARY SOURCE OF THIS INFORMATION?
(code below even if only one source = yes at A12)

	YES	NO
a. Study personnel	1	2
b. Chart abstraction	1	2
c. Direct contact with provider	1	2
d. Patient history	1	2
e. Other	1	2

_____
(SPECIFY)

A14. Name of person providing treatment on this date:

_____
(Please Print)

A15. Institution (Name or Number): _____
(Please Print)

_____

_____
(ADDRESS)