

**WOMEN'S INTERAGENCY HIV STUDY
ASCERTAINMENT TRACKING CHECKLIST (ATC)**

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

A2. WIHS STUDY VISIT #: _____

A3. FORM VERSION: **10/01/07**

A4. FORM COMPLETED BY: _____

A9. DOES WIHS SITE HAVE THE PARTICIPANT'S SIGNED MEDICAL RECORD RELEASE?

YES 1

NO 2

A10. INTERVIEWER INSTRUCTIONS: USE CHECKLIST DURING ADMINISTRATION OF THE INTERVIEW TO INDICATE WHETHER TO COLLECT FURTHER INFORMATION ABOUT SELF-REPORTED CONDITIONS. AT BOTTOM OF PAGE CLEARLY DOCUMENT DATE AND FACILITY OF ALL SELF-REPORTED CONDITIONS. MULTIPLE EPISODES OF AN EVENT MUST BE CLEARLY DELINEATED ON THE ATC. COLLECT MEDICAL RECORD RELEASE FORM FOR SHADED EVENTS.

- | | | |
|---|--|---|
| <input type="checkbox"/> C1a Cervical cancer | <input type="checkbox"/> C20d TB meds 3 mo or more | <input type="checkbox"/> E9 Candida trach/bronchi |
| <input type="checkbox"/> C3 Breast cancer | <input type="checkbox"/> C21b TB – Positive skin test | <input type="checkbox"/> E10 MAI / MAC |
| <input type="checkbox"/> C4 Cancer of the ovary | <input type="checkbox"/> C38 Liver biopsy | <input type="checkbox"/> E11 Toxoplasmosis |
| <input type="checkbox"/> C5 Cancer of the uterus | | <input type="checkbox"/> E12a CMV Retinitis |
| <input type="checkbox"/> C6 Kaposi's sarcoma | <input type="checkbox"/> C42ai Angina/chest pain hosp. | <input type="checkbox"/> E12b CMV – Blood |
| <input type="checkbox"/> C7 Lymphoma | <input type="checkbox"/> C42bi CHF hospitalization | <input type="checkbox"/> E12c CMV – GI tract |
| <input type="checkbox"/> C8 Lymphoma in brain | <input type="checkbox"/> C42c Heart attack or MI | <input type="checkbox"/> E12d CMV Hepatitis |
| <input type="checkbox"/> C9 Hodgkin's disease | <input type="checkbox"/> C42d Stroke or CVA | <input type="checkbox"/> E12e CMV – elsewhere in body |
| <input type="checkbox"/> C10 Skin cancer | <input type="checkbox"/> C42e TIA or mini-stroke | <input type="checkbox"/> E13 Meningitis |
| <input type="checkbox"/> C11 Liver cancer | <input type="checkbox"/> C44a Surgery on heart vessels | <input type="checkbox"/> E13a Cryptococcal Meningitis |
| <input type="checkbox"/> C12 Other cancer* | <input type="checkbox"/> E4i Diarrhea–Cryptosporidia | <input type="checkbox"/> E14a Crypto. infection of blood |
| <input type="checkbox"/> C14c Cancer – Metastatic | <input type="checkbox"/> E4ii Diarrhea–Microsporidia | <input type="checkbox"/> E14b Crypto. infection elsewhere |
| <input type="checkbox"/> C14e Cancer – Metastatic | <input type="checkbox"/> E4iii Diarrhea – Isospora | <input type="checkbox"/> E15 Histoplasmosis |
| <input type="checkbox"/> C15c Cancer – Metastatic | <input type="checkbox"/> E4iv Diarrhea – CMV | <input type="checkbox"/> E16 Coccidioidomycosis |
| <input type="checkbox"/> C15e Cancer – Metastatic | <input type="checkbox"/> E4v Diarrhea – MAI | <input type="checkbox"/> E17 Wasting syndrome |
| <input type="checkbox"/> C20 TB | <input type="checkbox"/> E5 Herpes Simplex of lungs | <input type="checkbox"/> E18 Dementia |
| <input type="checkbox"/> C20a TB in lungs | <input type="checkbox"/> E6 PCP | <input type="checkbox"/> E19 Salmonella |
| <input type="checkbox"/> C20b TB other part of body | <input type="checkbox"/> E7 Bacterial Pneumonia | <input type="checkbox"/> E20 PML |
| <input type="checkbox"/> C20c TB – Chest X-ray | <input type="checkbox"/> E8 Candida esophagus | |

b. REPORTED CONDITION	c. FORM & Q#	d. DATE OF DX	e. PROVIDER NAME & INSTITUTION

TURN FORM OVER TO COMPLETE ACSR ATC➔

**WOMEN'S INTERAGENCY HIV STUDY
ACSR (AIDS CANCER & SPECIMEN RESOURCE) ATC**

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

A2. WIHS STUDY VISIT #: ____ ____

A3. FORM VERSION: **10/01/07**

A4. FORM COMPLETED BY: ____ ____ ____

A9. DOES WIHS SITE HAVE THE PARTICIPANT'S SIGNED MEDICAL RECORD RELEASE?

YES 1

NO 2

*** COLLECT MEDICAL RECORD RELEASE FOR ALL BIOPSIES.**

A10. INTERVIEWER INSTRUCTIONS: USE CHECKLIST DURING ADMINISTRATION OF THE INTERVIEW TO INDICATE WHETHER TO COLLECT FURTHER INFORMATION ABOUT SELF-REPORTED BIOPSIES. CLEARLY DOCUMENT DATE AND FACILITY OF ALL SELF-REPORTED BIOPSIES.

	b. REPORTED BIOPSY	c. FORM & Q#	d. DATE OF BX	e. PROVIDER NAME & INSTITUTION
<input type="checkbox"/>	Lung biopsy *	E22a		
<input type="checkbox"/>	Skin Biopsy *	E22b		
<input type="checkbox"/>	Bone Marrow Biopsy *	E22c		
<input type="checkbox"/>	Cervical Biopsy *	E22d		
<input type="checkbox"/>	Uterine/Endometrial Biopsy	E22e		
<input type="checkbox"/>	Breast Biopsy *	E22f		
<input type="checkbox"/>	Other Biopsy *	E22g		