WOMEN'S INTERAGENCY HIV STUDY
CARDIOVASCULAR SUBSTUDY
CAROTID ULTRASOUND TRACKING FORM (CV01)

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

WIHS VISIT #: ___ ___

FORM COMPLETED BY: ___ ___ ___

VERSION DATE **10/01/04**

A1. DATE OF CAROTID ULTRASOUND VISIT: ___ ___ / ___ ___ / ___ ___
M D Y

A2. TIME VISIT STARTED: |___|___| : |___|___| AM 1
PM 2

A3. CAROTID ULTRASOUND TYPE

BASELINE .....1 **(A4)**
FOLLOW-UP 2

BASELINE QUALITY CONTROL.....3
FOLLOW-UP QUALITY CONTROL.....4

NOTE: THE USC READING CENTER WILL PROVIDE IMAGE ID FOR QUALITY CONTROL AND FOLLOW-UP SCANS ONLY.

a. IMAGE ID#: _____

A4. a. VIDEOTAPE #: _____

b. DATE VIDEOTAPE SENT TO USC: ___ ___ / ___ ___ / ___ ___
M D Y

A5. ULTRASOUND EQUIPMENT USED (CIRCLE APPROPRIATE CODE):

Bronx: US – Philips US ATL5000 (SN 4000-0318-06); probe – Sedon (SN D8500-0030-01).....1
Brooklyn: US – Philips, model SONOS 5500 (SN 9708A04148); probe – Agilent 11-3L, model 21356A (SN US99301470) 2
Washington DC: US – Philips, model IE33 (SN 02RDVH); probe – Philips L9-3, (SN 035JZO) 9
Los Angeles: US – ATL Apogee 800 Plus (SN 00KYQW); probe: Linear 5 MHz (SN 7-4L40) 4
San Francisco: US – Sequoia 512 (SN 55258); probe – 8L54116 (SN 10391001) 5
Chicago: US – GE VIVID7 (SN 9832V7L); probe – GE 9L model 5131433 (SN 18717YP9)..... 10

OTHER.....7
SPECIFY: _____
_____
_____
_____

WIHS ID #

A6. WAS PROCEDURE COMPLETED **(CIRCLE YES OR NO FOR EACH)**?

	YES	NO	i. REASON NOT COMPLETED
a. ECG TRACE DISPLAY ON SCREEN	1 **(b)**	2	_____
b. RIGHT CCA IMT SCAN	1 **(c)**	2	_____
c. RIGHT CAROTID BIF IMT SCAN	1 **(d)**	2	_____
d. RIGHT ICA IMT SCAN	1 **(e)**	2	_____
e. RIGHT ECA IMT SCAN	1 **(A7)**	2	_____

A7. IMAGING LESIONS PRESENT?

YES 1
NO ..... 2 **(A8)**

a. LOCATION: _____

b. COMMENTS: _____

_____

A8. WAS THERE A CLINICAL ALERT?

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

PROMPT: IF RESPONSE TO QUESTION A8 IS "YES," ULTRASOUND TECHNICIAN SHOULD SEND TAPE TO READING CENTER AT USC *IMMEDIATELY* AND COMPLETE COMMENTS FIELD BELOW WITH DESCRIPTION OF CONDITION REQUIRING ALERT.

a. COMMENTS: _____

_____

A9. SUPINE BLOOD PRESSURE READINGS (POST-SCAN).

NOTE: ALWAYS WAIT FOR 60 SECONDS BEFORE TAKING THE NEXT MEASUREMENT.

	a. SYSTOLIC		b. DIASTOLIC	c. HR
1.	|___|___|___|	/	|___|___|___|	|___|___|___|
2.	|___|___|___|	/	|___|___|___|	|___|___|___|
3.	|___|___|___|	/	|___|___|___|	|___|___|___|
4.	|___|___|___|	/	|___|___|___|	|___|___|___|
5.	|___|___|___|	/	|___|___|___|	|___|___|___|

A10. WERE THERE ANY PROBLEMS ASSOCIATED WITH OBTAINING THE CAROTID ULTRASOUND?

YES 1
NO ..... 2 **(SECTION B)**

a. COMMENTS: _____

_____

WIHS ID #

B. QUESTIONS FOR PARTICIPANT

B1. Are you currently taking any prescription medicine(s) to treat heart disease, high blood pressure or hypertension?

YES 1
NO ..... 2 **(B2)**

a. When did you last take any of these medications?

___ ___ / ___ ___ / ___ ___ (M / D / Y) |___|___| : |___|___| AM ..... 1 PM 2

B2. TIME VISIT ENDED: |___|___| : |___|___| AM ..... 1 PM 2

C. CONTACT INFORMATION

NOTE: CONTACT INFORMATION WILL BE COLLECTED BUT NOT ENTERED INTO APOLLO.

C1. CLINIC CONTACT INFORMATION:

a. SITE NAME: _____

b. ADDRESS: _____

_____

c. NAME OF CONTACT PERSON: _____

d. PHONE: _____

e. FAX: _____

C2. ULTRASOUND LAB CONTACT INFORMATION:

a. ULTRASOUND LAB NAME: _____

b. ADDRESS: _____

_____

c. NAME OF CONTACT PERSON: _____

d. PHONE: _____

e. FAX: _____

C3. ULTRASONOGRAPHER SIGNATURE: _____

C4. ULTRASONOGRAPHER PRINTED NAME: _____