OMB NO: 0920-0740
EXPIRATION DATE: 06/30/2010

Medical Monitoring Project (MMP)
Medical Record Abstraction Form
Surveillance Period Summary Form (SPSF)
VERSION 2.0.4

OPTIONAL- FOR LOCAL USE ONLY

MMP SPSF v2.0.4

MMP Participant ID: **Facility ID:**

Medical record number:

Patient name:

Physician name:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control & Prevention

Medical Monitoring Project (MMP)
Medical Record Abstraction Form
Surveillance Period Summary Form (SPSF) v2.0.4

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

I. ABSTRACTION AND IDENTIFICATION

MMP Participant ID:

Surveillance Period (SP)

SP start date: Mo. / Day / Year (12 months prior to date of interview OR 1st contact attempt if no interview obtained)

SP end date: Mo. / Day / Year (date of interview OR 1st contact attempt if no interview obtained)

Facility ID:

Date of abstraction: Mo. / Day / Year

Abstractor ID:

II. PATIENT DEMOGRAPHICS

Most recent height (ft/in) during the SP:

ft. ' inches "

○ Height not documented

III. SURVEILLANCE PERIOD SUMMARY FORM SECTIONS - OPTIONAL

Is there documentation of any of the following during the SP?
○ Yes → Select all that are documented below.
○ No → This form is now complete except for optional section XIII (Remarks).

○ Type of reimbursement for medical care or other services at this facility → **Complete section IV.**	○ Pregnancy (females only) → **Complete section IX.**
○ Provision of other services at this facility → **Complete section V.**	○ Family history of diabetes, hypercholesterolemia, hypertension, or ischemic heart disease including myocardial infarction (MI) → **Complete section X.**
○ Screening for tuberculosis (TB), or for cervical or anal cancer → **Complete section VI.**	○ Death of the patient → **Complete section XI.**
○ Whether or not hepatitis A, B, A and B, influenza or pneumococcal immunizations were given → **Complete section VII.**	○ Visits to other facilities for HIV care → **Complete section XII.**
○ Referrals for other services → **Complete section VIII.**	

IV. REIMBURSEMENT

Is there documentation of the type of reimbursement for medical care or other services at this facility during the SP?
○ Yes → Select all that are documented below, including that the patient had no method of reimbursement during all or part of the SP ("None/Self-pay").
○ No

1 ○ AIDS Drug Assistance Program
2 ○ CHAMPUS/Tricare
3 ○ Clinical Trial/Clinical Study
4 ○ Medicaid
5 ○ Medicare
6 ○ None/Self-pay (during all or part of the SP)
7 ○ Private (including HMO/PPO)
8 ○ Prison/Jail
9 ○ Ryan White (excluding ADAP)
10 ○ Veterans Administration
11 ○ Other public insurance, Specify:
12 ○ Other public insurance, Specify:
13 ○ Other insurance, Specify:
14 ○ Other, Specify:

V. OTHER SERVICES

Is there documentation that other services were provided at this facility during the SP?
○ Yes → Select all that are documented below.
○ No

1 ○ Case management	9 ○ Nutritional counseling
2 ○ Chemotherapy	10 ○ Physical therapy
3 ○ Dental care	11 ○ Prenatal care
4 ○ Dialysis	12 ○ Receipt of equipment or supplies
5 ○ Education session	13 ○ Substance abuse counseling or treatment
6 ○ Hospice care	14 ○ Support group
7 ○ Mental health counseling or treatment	15 ○ Pharmacist consultation
8 ○ Nursing home care	

16 ○ Other, Specify:
17 ○ Other, Specify:
18 ○ Other, Specify:
19 ○ Other, Specify:
20 ○ Other, Specify:
21 ○ Other, Specify:

VI. TUBERCULOSIS (TB), CERVICAL AND ANAL CANCER SCREENING

Is there documentation of screening for tuberculosis (TB), or cervical or anal cancer, during the SP?
○ Yes → Enter all that are documented for each screening below.
○ No

Was screening for tuberculosis (TB) performed during the SP? (select one)
[1]○ Yes, screening done → Enter all that are documented below.
[2]○ No, documented that screening was not done
[3]○ TB screening not documented

Date of the most recent tuberculin skin test (TST/PPD/Mantoux) or QuantiFERON test (QFT) during the SP:

Mo. / Year ○ Date not documented

Result of the most recent TST/PPD/Mantoux or QFT test during the SP: (enter one for TST/PPD/Mantoux **OR** one for QFT)

TST/PPD/Mantoux: (enter OR select one)

Result in millimeters: ____

[1]○ Positive, no value reported
[2]○ Negative, no value reported
[3]○ Not read
[4]○ Anergic
[5]○ Not documented

OR

QFT: (select one)

[1]○ QFT positive
[2]○ QFT negative
[3]○ QFT indeterminate
[4]○ Not documented

Was screening for cervical or anal cancer performed during the SP? (select one Yes, No, or Not documented choice)

[1]○ Yes, screening done → Select all that apply:
[2]○ No, documented that screening was not done
[3]○ Cervical and anal cancer screening not documented

Site	Most Recent Result (select one for each documented site)		
[1]○ Cervical	[1]○ Normal	[2]○ Abnormal	[3]○ Not documented
[2]○ Anal	[1]○ Normal	[2]○ Abnormal	[3]○ Not documented
[3]○ Unspecified	[1]○ Normal	[2]○ Abnormal	[3]○ Not documented

VII. HEPATITIS, INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS

Is there documentation of whether or not hepatitis A, B, A and B, influenza or pneumococcal immunizations were given during the SP?
○ Yes → Enter all that are documented for each vaccine below.
○ No

Was hepatitis A vaccine (Havrix, Vaqta) given during the SP? (select one Yes, No or Not documented choice)

[1]○ Yes → Enter a maximum of 2 documented doses and dates:

Dose No.	Date (Mo / Year)	Date not documented
____	/	○
____	/	○

[2]○ Yes, but number of doses not documented

[3]○ No, documented that vaccine was not given → **Reason vaccine not given:** (select one)
○ Prior vaccination ○ Patient declined
○ Previously infected ○ Not documented

[4]○ Hepatitis A vaccination not documented

Was hepatitis B vaccine (Energix B, Recombivax) given during the SP? (select one Yes, No or Not documented choice)

[1]○ Yes → Enter a maximum of 3 documented doses and dates:

Dose No.	Date (Mo / Year)	Date not documented
____	/	○
____	/	○
____	/	○

[2]○ Yes, but number of doses not documented

[3]○ No, documented that vaccine was not given → **Reason vaccine not given:** (select one)
○ Prior vaccination ○ Patient declined
○ Previously infected ○ Not documented

[4]○ Hepatitis B vaccination not documented

VII. HEPATITIS, INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS cont'd

Was combination hepatitis A and B vaccine (Twinrix) given during the SP? (select one Yes, No or Not documented choice)

[1] ○ Yes → Enter a maximum of 3 documented doses and dates:

[2] ○ Yes, but number of doses not documented

[3] ○ No, documented that vaccine was not given → **Reason vaccine not given:** (select one)
○ Prior vaccination ○ Patient declined
○ Previously infected ○ Not documented

[4] ○ Hepatitis A and B vaccination not documented

Dose No.	Date (Mo / Year)	Date not documented
	/	○
	/	○
	/	○

Was influenza vaccine (flushield, fluzone) given during the SP? (select one Yes, No or Not documented choice)

[1] ○ Yes → Enter the most recent documented dose and date:

[2] ○ No, documented that vaccine was not given → **Reason vaccine not given:** (select one)
○ Patient declined ○ Allergy to vaccine components
○ Not documented

[3] ○ Influenza vaccination not documented

Dose No.	Date (Mo / Year)	Date not documented
	/	○

Was pneumococcal vaccine (Pneumovax 23, Pneu-Immune 23) given during the SP? (select one Yes, No or Not documented choice)

[1] ○ Yes → Enter the most recent documented dose and dates:

[2] ○ No, documented that vaccine was not given → **Reason vaccine not given:** (select one)
○ Prior vaccination ○ Patient declined
○ Not documented

[3] ○ Pneumococcal vaccination not documented

Dose No.	Date (Mo / Year)	Date not documented
	/	○

VIII. REFERRALS

Is there documentation of any of the following referrals during the SP?
○ Yes → Select all that are documented below.
○ No

[1] ○ Adherence support	[8] ○ Mental health services
[2] ○ Case manager services	[9] ○ Partner counseling and referral services
[3] ○ Financial assistance	[10] ○ Reproductive health services
[4] ○ Food and housing support services	[11] ○ Social worker services
[5] ○ HIV prevention counseling services	[12] ○ Substance abuse prevention services
[6] ○ Home-based care services	[13] ○ TB treatment services
[7] ○ Intimate partner violence services	

IX. PREGNANCIES AND OUTCOMES (FEMALES ONLY)

Is there documentation that the patient was pregnant during the SP?
○ Yes → Enter all that are documented for each pregnancy below.
○ No

Number of pregnancies that occurred during the SP: ○ 1 ○ 2 ○ 3 or more

Outcome of the first pregnancy during the SP: (select one and enter date)

[1] ○ Elective abortion
[2] ○ Intrauterine fetal death → Select one delivery method:
[3] ○ Live birth → Select one delivery method:
[4] ○ Spontaneous abortion/miscarriage
[5] ○ Still pregnant
[6] ○ Not documented

Date of first outcome: / (Mo / Year) ○ Date not documented

Delivery method for the first pregnancy during the SP:
[1] ○ Cesarean section (elective)
[2] ○ Cesarean section (not elective)
[3] ○ Induced vaginal delivery
[4] ○ Spontaneous vaginal delivery
[5] ○ Not documented

IX. PREGNANCIES AND OUTCOMES (FEMALES ONLY) cont'd

Outcome of the second pregnancy during the SP:
(select one and enter date)

1 ○ Elective abortion
2 ○ Intrauterine fetal death → Select one delivery method:
3 ○ Live birth → Select one delivery method:
4 ○ Spontaneous abortion/miscarriage
5 ○ Still pregnant
6 ○ Not documented

Date of second outcome: Mo / Year ○ Date not documented

Delivery method for the second pregnancy during the SP:
1 ○ Cesarean section (elective)
2 ○ Cesarean section (not elective)
3 ○ Induced vaginal delivery
4 ○ Spontaneous vaginal delivery
5 ○ Not documented

Outcome of the third pregnancy during the SP:
(select one and enter date)

1 ○ Elective abortion
2 ○ Intrauterine fetal death → Select one delivery method:
3 ○ Live birth → Select one delivery method:
4 ○ Spontaneous abortion/miscarriage
5 ○ Still pregnant
6 ○ Not documented

Date of third outcome: Mo / Year ○ Date not documented

Delivery method for the third pregnancy during the SP:
1 ○ Cesarean section (elective)
2 ○ Cesarean section (not elective)
3 ○ Induced vaginal delivery
4 ○ Spontaneous vaginal delivery
5 ○ Not documented

X. FAMILY HISTORY

Is there documentation of family history of any of the following conditions during the SP?
○ Yes → Select all that are documented below.
○ No

1 ○ Diabetes Mellitus
2 ○ Hypercholesterolemia
3 ○ Hypertension
4 ○ Ischemic heart disease, including myocardial infarction (MI)

XI. MORTALITY DATA

Is there documentation that the patient died during the SP?
○ Yes → Enter all that are documented below.
○ No

Date of death during the SP: Mo. / Day / Year ○ Date not documented

Cause of death: (select one) ○ Accident ○ Suicide ○ Other, Specify:_____
○ Homicide ○ Natural ○ Cause not documented

Diagnoses at death: (enter all documented diagnoses) ○ Diagnosis not documented

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

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MMP Participant ID: **Facility ID:**

XII. OTHER FACILITIES

Is there documentation that the patient visited other facilities for HIV care during the SP?

◯ Yes → Enter all facilities that are documented below.
◯ No

Facility/Provider Name	Contact Information
1.	Street: City: State: ZIP code: - Telephone: - -
2.	Street: City: State: ZIP code: - Telephone: - -
3.	Street: City: State: ZIP code: - Telephone: - -
4.	Street: City: State: ZIP code: - Telephone: - -
5.	Street: City: State: ZIP code: - Telephone: - -

XII. OTHER FACILITIES cont'd

Facility/Provider Name	Contact Information
6.	Street: City: State: ZIP code: Telephone:
7.	Street: City: State: ZIP code: Telephone:
8.	Street: City: State: ZIP code: Telephone:
9.	Street: City: State: ZIP code: Telephone:
10.	Street: City: State: ZIP code: Telephone:

XII. OTHER FACILITIES cont'd

Facility/Provider Name	Contact Information
11. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____
12. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____
13. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____
14. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____
15. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____

XII. OTHER FACILITIES cont'd

Facility/Provider Name	Contact Information
16. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____
17. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____
18. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____
19. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____
20. _____	**Street:** _____ _____ **City:** _____ **State:** _____ _____ **ZIP code:** _____ **Telephone:** _____

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MMP Participant ID: | | | | | | | | | | | | | | |

Facility ID: | | | | | | | | |

XIII. REMARKS