

**Medical Monitoring Project (MMP)
Medical Record Abstraction Form
2009 Surveillance Period Summary Form (SPSF)
VERSION 4.0.0**

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OPTIONAL- FOR LOCAL USE ONLY

<i>MMP SPSF v4.0.0</i>		Abstraction Facility ID:	
MMP Participant ID:			(ID of the facility where abstraction is being conducted)
Medical record number:			
Patient name:			
Physician name:			



**Medical Monitoring Project (MMP)
Medical Record Abstraction Form**

2009 Surveillance Period Summary Form (SPSF) v4.0.0



I. ABSTRACTION AND IDENTIFICATION

MMP Participant ID:

Surveillance Period (SP)

SP start date:

(12 months prior to date of interview OR 1st contact attempt if no interview obtained)

SP end date:

(date of interview OR 1st contact attempt if no interview obtained)

Date of abstraction:

Abstractor ID:

Abstraction Facility ID:

(ID of the facility where abstraction is being conducted)

Was the documented care abstracted with this form given at another facility (i.e., outside the Abstraction Facility)?

Yes

Complete information about the "Care" Facility → Enter Care Facility ID or indicate that Care Facility was not documented or was outside jurisdiction:

Care Facility ID

(ID of the facility where the documented care was provided)

No

Continue to Section II below

Care Facility not documented or outside jurisdiction

II. PATIENT DEMOGRAPHICS

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

Height not documented

Patient's country of residence during the surveillance period (select ALL that apply):

United States

Canada

Mexico

Other, Specify:

Not documented/Could not be determined from residence address

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 coverage for medical care or other services
→ Complete section IV.

Pregnancy (females only)
→ Complete section IX.

Provision of other services at this facility
→ Complete section V.

Reported or suspected substance abuse
→ 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. COVERAGE FOR MEDICAL CARE

Is there documentation of the type of coverage for medical care or other services during the SP?

- Yes → Select all that are documented below, including if the patient had no medical coverage during all or part of the SP ("None/Self-pay").
 No

- | | |
|---|---|
| <p>¹ <input type="radio"/> AIDS Drug Assistance Program (ADAP)</p> <p>² <input type="radio"/> CHAMPUS/Tricare</p> <p>³ <input type="radio"/> Clinical Trial/Clinical Study</p> <p>⁴ <input type="radio"/> Medicaid</p> <p>⁵ <input type="radio"/> Medicare</p> | <p>⁶ <input type="radio"/> None/Self-pay (during all or part of the SP)</p> <p>⁷ <input type="radio"/> Private (including HMO/PPO)</p> <p>⁸ <input type="radio"/> Prison/Jail</p> <p>⁹ <input type="radio"/> Ryan White (excluding ADAP)</p> <p>¹⁰ <input type="radio"/> Veterans Administration</p> |
|---|---|
- 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

- | | |
|--|--|
| <p>¹ <input type="radio"/> Case management</p> <p>² <input type="radio"/> Chemotherapy</p> <p>³ <input type="radio"/> Dental care</p> <p>⁴ <input type="radio"/> Dialysis</p> <p>⁵ <input type="radio"/> Education session</p> <p>⁶ <input type="radio"/> Hospice care</p> <p>⁷ <input type="radio"/> Mental health counseling or treatment</p> <p>⁸ <input type="radio"/> Nursing home care</p> | <p>⁹ <input type="radio"/> Nutritional counseling</p> <p>¹⁰ <input type="radio"/> Physical therapy</p> <p>¹¹ <input type="radio"/> Prenatal care</p> <p>¹² <input type="radio"/> Receipt of equipment or supplies</p> <p>¹³ <input type="radio"/> Substance abuse counseling or treatment</p> <p>¹⁴ <input type="radio"/> Support group</p> <p>¹⁵ <input type="radio"/> Pharmacist consultation</p> |
|--|--|
- 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

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)

1 **Yes** → Enter a maximum of 4 documented doses and dates: **Dose No.** **Date** Date not documented
(If documented)

2 **Yes – but number of doses not documented**

3 <input type="radio"/> No – documented that vaccine was not given Reason vaccine not given: (select one) <ul style="list-style-type: none"> <input type="radio"/> Prior vaccination <input type="radio"/> Patient declined <input type="radio"/> Previously infected <input type="radio"/> Not documented <input type="radio"/> Other, specify <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	→	<div style="text-align: center; font-size: small;">Mo. Year</div> <div style="text-align: center; font-size: x-small;">/</div>	○
	→	<div style="text-align: center; font-size: small;">Mo. Year</div> <div style="text-align: center; font-size: x-small;">/</div>	○
	→	<div style="text-align: center; font-size: small;">Mo. Year</div> <div style="text-align: center; font-size: x-small;">/</div>	○
	→	<div style="text-align: center; font-size: small;">Mo. Year</div> <div style="text-align: center; font-size: x-small;">/</div>	○

4 **Hepatitis A and B vaccination not documented**

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

1 **Yes** → Enter the date of the most recent dose: **Date** Date not documented
(If documented)

2 **No – documented that vaccine was not given**
Reason why vaccine not given: (select one)

- Allergy to vaccine components
- Patient declined
- Other, specify
- Not documented

3 **Influenza vaccination not documented**

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

1 **Yes** → Enter the date of the most recent dose: **Date** Date not documented
(If documented)

2 **No – documented that vaccine was not given**
Reason why vaccine not given: (select one)

- Prior vaccination
- Patient declined
- Other, specify
- Not documented

3 **Pneumococcal vaccination 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 <input type="radio"/> Adherence support	8 <input type="radio"/> Intimate partner violence services
2 <input type="radio"/> Case manager services	9 <input type="radio"/> Mental health services
3 <input type="radio"/> Dental care	10 <input type="radio"/> Partner counseling and referral services
4 <input type="radio"/> Financial assistance	11 <input type="radio"/> Reproductive health services
5 <input type="radio"/> Food and housing support services	12 <input type="radio"/> Social worker services
6 <input type="radio"/> HIV prevention counseling services	13 <input type="radio"/> Substance abuse prevention services
7 <input type="radio"/> Home-based care services	14 <input type="radio"/> TB treatment 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

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. SUBSTANCE ABUSE

Is there documentation of reported or suspected alcohol abuse or other non-prescribed use of substances, including counseling or treatment for alcohol and/or substance use/abuse, during the SP?

- Yes → Enter all that are documented below.
 No

Alcohol abuse

Is there documentation of alcohol abuse during the SP? Yes No

Other non-prescribed use of substances

Is there evidence of any injection substance use (e.g., track marks) documented during the SP? Yes No

X. SUBSTANCE ABUSE cont'd

Non-prescribed use of substances documented during the SP: (select all that are documented and type of use)

Substance	Type of Use <small>(select all that apply OR select Not documented)</small>		
	Injection	Non-Injection	Not documented
<input type="radio"/> 1 Amphetamines (other than methamphetamines)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 2 Cocaine (other than crack)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 3 Crack cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 4 Ecstasy (MDMA, X)			
<input type="radio"/> 5 GHB			
<input type="radio"/> 6 Hallucinogens such as LSD or mushrooms			
<input type="radio"/> 7 Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 8 Ketamine (Special K)			
<input type="radio"/> 9 Marijuana			
<input type="radio"/> 10 Methadone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 11 Methamphetamines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 12 Painkillers such as Oxycontin, Vicodin or Percocet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 13 Poppers (amyl nitrate)			
<input type="radio"/> 14 Rohypnol			
<input type="radio"/> 15 Steroids/Hormones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 16 Tranquilizers such as Valium, Ativan, or Xanax			
<input type="radio"/> 17 Viagra, Levitra or Cialis			
<input type="radio"/> 18 Other, Specify: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 19 Other, Specify: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 20 Other, Specify: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 21 Substance not specified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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:

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(ID of the facility where abstraction is being conducted)

XII. OTHER FACILITIES cont'd

Facility/Provider Name	Contact Information
1. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>
2. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>
3. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>
4. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>
5. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>

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XII. OTHER FACILITIES cont'd

Facility/Provider Name	Contact Information
6. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>
7. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>
8. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>
9. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>
10. _____ _____ _____ _____	Street: _____ _____ City: _____ State: _____ ZIP code: <input type="text"/> Telephone: <input type="text"/>

