OMB NO: 0920-0740
EXPIRATION DATE: 05/31/2012

Medical Monitoring Project (MMP)
Medical Record Abstraction Form
2011 Surveillance Period Summary Form (SPSF)
VERSION 7.0.0

OPTIONAL- FOR LOCAL USE ONLY

MMP SPSF v7.0.0

MMP Participant ID:

Abstraction Facility ID:
(ID of the facility where abstraction is being conducted)

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
2011 Surveillance Period Summary Form (SPSF) v7.0.0

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)

Date of abstraction: / / (Mo. / Day / Year)

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:
′ ″ (ft. / inches)
○ Height not documented

Patient's country of residence during the surveillance period (select ALL that apply)**:**
1○ United States
2○ Canada
3○ Mexico
4○ Other, Specify:
5○ 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

[1] ○ AIDS Drug Assistance Program (ADAP)
[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 <u>each</u> 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 <u>most recent</u> tuberculin skin test (TST/PPD/Mantoux) or QuantiFERON test (QFT) during the SP:

Mo. / Year

○ Date not documented

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

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)

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 ○ Indeterminate	4 ○ Not documented
2 ○ Anal	1 ○ Normal	2 ○ Abnormal	3 ○ Indeterminate	4 ○ Not documented
3 ○ Unspecified	1 ○ Normal	2 ○ Abnormal	3 ○ Indeterminate	4 ○ 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)

1 ○ **Yes** → Enter a maximum of 2 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
○ Other, specify

	Dose No. (If documented)	Date (Mo. / Year)	Date not documented
1		/	○
2		/	○

4 ○ **Hepatitis A vaccination not documented**

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

1 ○ **Yes** → Enter a maximum of 4 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
○ Other, specify

	Dose No. (If documented)	Date (Mo. / Year)	Date not documented
1		/	○
2		/	○
3		/	○
4		/	○

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)

[1] ○ **Yes** → Enter a maximum of 4 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
- ○ Other, specify

[4] ○ **Hepatitis A and B vaccination not documented**

	Dose No. (If documented)	Date (Mo. / Year)	Date 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:

[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**

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)

[1] ○ **Yes** → Enter the date of the most recent dose:

[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**

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] ○ Intimate partner violence services
[2] ○ Case manager services	[9] ○ Mental health services
[3] ○ Dental care	[10] ○ Partner counseling and referral services
[4] ○ Financial assistance	[11] ○ Reproductive health services
[5] ○ Food and housing support services	[12] ○ Social worker services
[6] ○ HIV prevention counseling services	[13] ○ Substance abuse prevention services
[7] ○ Home-based care services	[14] ○ 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 (select all that apply **OR** select Not documented)		
	Injection	**Non-Injection**	**Not documented**
[1] ○ Amphetamines (other than methamphetamines)	○	○	○
[2] ○ Cocaine (other than crack)	○	○	○
[3] ○ Crack cocaine	○	○	○
[4] ○ Ecstasy (MDMA, X)			
[5] ○ GHB			
[6] ○ Hallucinogens such as LSD or mushrooms			
[7] ○ Heroin	○	○	○
[8] ○ Ketamine (Special K)			
[9] ○ Marijuana			
[10] ○ Methadone	○	○	○
[11] ○ Methamphetamines	○	○	○
[12] ○ Painkillers such as Oxycontin, Vicodin or Percocet	○	○	○
[13] ○ Poppers (amyl nitrate)			
[14] ○ Rohypnol			
[15] ○ Steroids/Hormones	○	○	○
[16] ○ Tranquilizers such as Valium, Ativan, or Xanax			
[17] ○ Viagra, Levitra or Cialis			
[18] ○ Other, Specify:	○	○	○
[19] ○ Other, Specify:	○	○	○
[20] ○ Other, Specify:	○	○	○
[21] ○ Substance not specified	○	○	○

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.**

XII. OTHER FACILITIES cont'd

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: - -

OPTIONAL - FOR LOCAL USE ONLY

MMP SPSF v7.0.0

MMP Participant ID:

Abstraction Facility ID:

(ID of the facility where abstraction is being conducted)

XIII. REMARKS