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

Medical Monitoring Project (MMP)
Medical Record Abstraction Form
2008 Surveillance Period Summary Form (SPSF)
VERSION 3.0.0

OPTIONAL- FOR LOCAL USE ONLY

MMP SPSF v3.0.0

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
2008 Surveillance Period Summary Form (SPSF) v3.0.0

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)

○ **Care Facility not documented or outside jurisdiction**

○ **No**
Continue to Section II below

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 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

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

4 ◯ **Hepatitis A vaccination not documented**

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

4 ◯ **Hepatitis B vaccination not documented**

Dose No. (If documented)	Date (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:

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:

Date (Mo. / Year)	Date not 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 (Mo. / Year)	Date not 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 ◯ 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.**

FOR LOCAL USE ONLY

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MMP Participant ID:

Abstraction Facility ID:
(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: - 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

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MMP Participant ID:

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XIII. REMARKS