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

Medical Monitoring Project (MMP)
Medical Record Abstraction Form
2012 Surveillance Period Summary Form (SPSF)
VERSION 7.1.0

OPTIONAL- FOR LOCAL USE ONLY

MMP SPSF v7.1.0

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)
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2012 Surveillance Period Summary Form (SPSF) v7.1.0

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)

○ **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.**

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○ 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)	6 ○ None/Self-pay (during all or part of the SP)
2 ○ CHAMPUS/Tricare	7 ○ Private (including HMO/PPO)
3 ○ Clinical Trial/Clinical Study	8 ○ Prison/Jail
4 ○ Medicaid	9 ○ Ryan White (excluding ADAP)
5 ○ Medicare	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

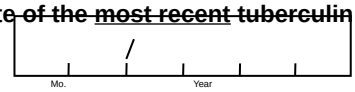
Was screening for tuberculosis (TB) performed during the SP? (select one)

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



○ 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 ____

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

1 ○ **Yes** → Enter a maximum of 4 documented doses and dates:

Dose No. (If documented)	**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
○ Other, specify

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 (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 <u>injection</u> 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.**
	10.

5.	

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:

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MMP SPSF v7.1.0

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
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: ☐☐☐-☐☐☐-☐☐☐☐

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XIII. REMARKS