1. Login Screen

Login

RWHAP Chart Abstraction

Login

E-Mail Address

Password

Login

OMB No. 0906 – xxxx Expiration Date XX/XX/20XX

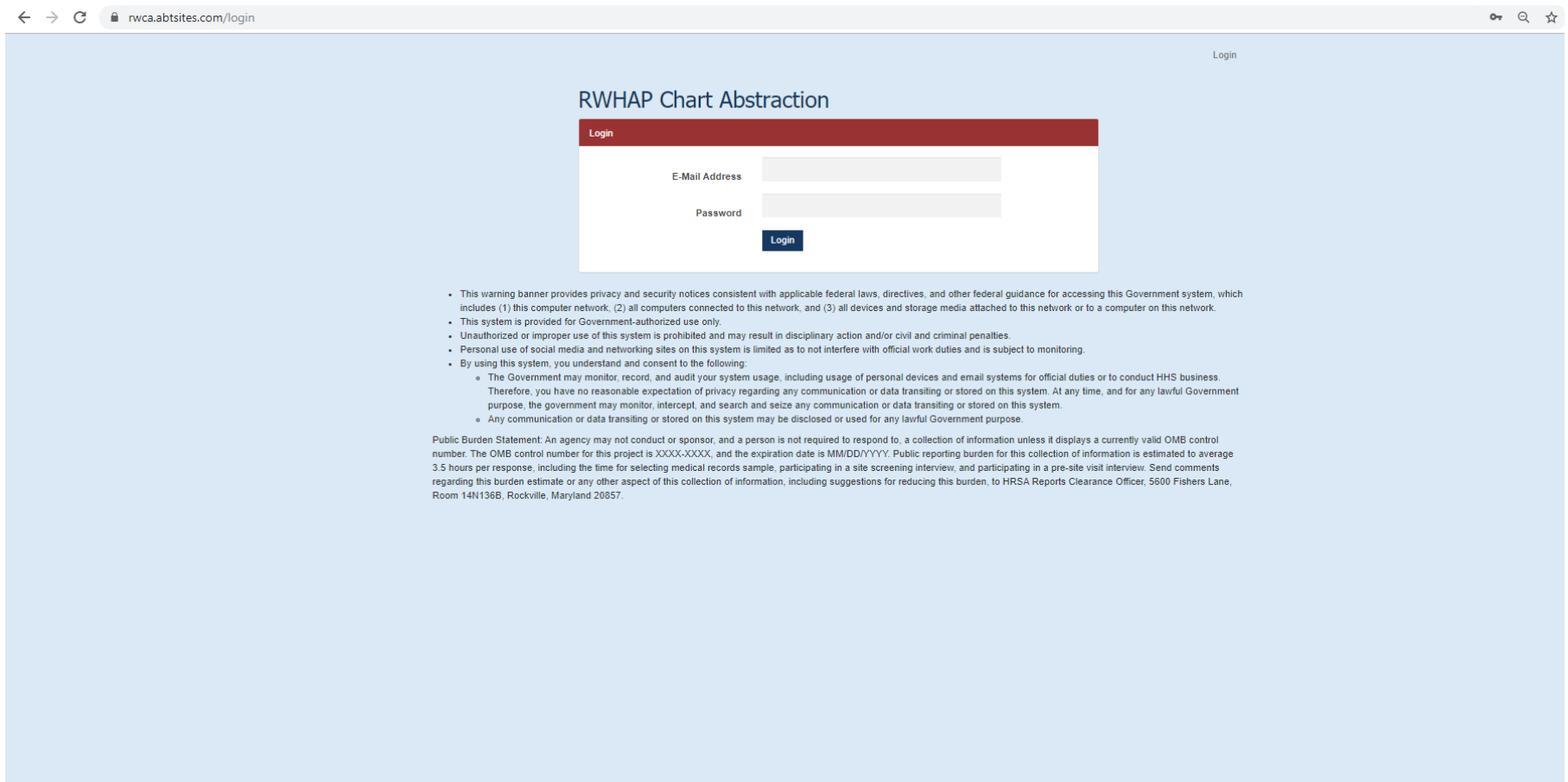## 2. Creation of de-identified eUCI number

RWHAP Chart Abstraction

New Chart Abstraction Form

First and third letters of first name:

First and third letters of last name:

Date of birth: Enter January 1 if month and date are unknown

mm/dd/yyyy

Current Gender:

- ○ Male
- ○ Transgender
- ○ Female
- ○ Unknown

[Cancel]   [Next →]

3. Top Navigation

RWHAP Chart Abstraction   🏠 Home 👤 ▬▬▬▬

| Client Information / Demographics | Medical Visits | Medications | Laboratory Testing | Vaccines |

Unique Client ID: ▬▬▬▬▬▬▬▬   Review period is January 1, 2017 - December 31, 2018

4. Footer Navigation

[← Previous]   [Save as Pending]   [Finish and Submit]

5. Client Information/ Demographics Screen

Site ID:

Reviewer Initials:

Date of Review:
mm/dd/yyyy

Start & end time of chart review (in mins):
Start: --:-- -- End: --:-- --

Year of birth: yyyy

☐ Not documented

Current gender: `clear`

○ Male
○ Female
○ Transgender (Male to Female)
○ Transgender (Female to Male)
○ Transgender (Other)
○ Not documented

Sex at birth: `clear`

○ Male
○ Female
○ Not documented

Housing status: `clear`

○ Stable Permanent Housing
○ Temporary Housing
○ Unstable Housing
○ Not documented

Race: (check all that apply) `clear`

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other:
☐ Not documented

Ethnicity: `clear`

○ Hispanic/Latino/or Spanish origin
○ Non-Hispanic/Latino/or Spanish origin
○ Not documented

Annual Household income: `clear` $

☐ Not documented

Number of people in household:

☐ Not documented

Medical insurance: (check all that apply) `clear`

☐ Private—Employer
☐ Private—Individual
☐ Medicare
☐ Medicaid
☐ CHIP, or other public plan
☐ Veterans Health Administration (VA), military health care (TRICARE), and other military health care
☐ Indian Health Service
☐ No insurance/uninsured
☐ Other
☐ Not documented

HIV risk: (check all that apply) `clear`

☐ Male-to-male sexual contact (MSM)
☐ Injection Drug Use (IDU)
☐ Hemophilia/coagulation disorder
☐ Heterosexual contact
☐ Receipt of blood transfusion, blood components, or tissue
☐ Perinatal transmission
☐ Risk factor not reported or not identified

HIV diagnosis year: yyyy

☐ Date unknown

Date 1st HIV medical visit at site: mm/dd/yyyy

☐ Date unknown

Patient status at the end of the review period:

○ Alive ○ Deceased

mm/yyyy ☐ Date of death unknown

Use 99 for the month if unknown (Ex: 99/2000)

Services received during the review period: (check all that apply) `clear`

☐ HIV care only
☐ HIV and primary care
☐ HIV and other healthcare and supportive services
   ☐ Other healthcare and supportive services provided onsite with medical care clinic
   ☐ Other healthcare and supportive services provided in network/not onsite with medical care clinic
   ☐ Other healthcare and supportive services provided onsite with medical care and in network/not onsite with medical care clinic
☐ HIV, primary, and other healthcare and supportive services
   ☐ Other healthcare and supportive services provided onsite with medical care clinic
   ☐ Other healthcare and supportive services provided in network/not onsite with medical care clinic
   ☐ Other healthcare and supportive services provided onsite with medical care and in network/not onsite with medical care clinic

6. HIV Medical Visit Screen

HIV Medical Visit #1

Date of visit with HIV medical provider with prescribing privileges:

mm/dd/yyyy ☐ Client did not show up for the visit

Blood pressure readings at visit:

Systolic: _____ ☐ Not documented

Diastolic: _____ ☐ Not documented

Is client sexually active: `clear`
- ○ Yes
- ○ No
- ○ Not documented

If female, is patient pregnant at this visit? `clear`
- ○ Yes
- ○ No
- ○ Not documented

First noted date of pregnancy, if applicable: `clear` mm/dd/yyyy
- ○ N/A Pregnancy ongoing
- ○ Not applicable / not documented

Pregnancy outcome at this visit: `clear`
- ○ Pregnancy ongoing
- ○ Live birth
- ○ Pregnancy did not result in live birth
- ○ Not applicable / not documented

Date sexual history discussed: `clear` mm/dd/yyyy ☐ Not documented

Was a mental health screening done during the visit: `clear`
- ○ Yes
- ○ No
- ○ Not documented

Type of mental health screening tests: (check all that apply) `clear`
- ☐ PHQ-2
- ☐ SAMISS
- ☐ PHQ-9
- ☐ CES-D
- ☐ GAD-7
- ☐ Abbreviated PCL-C
- ☐ Kessler 6 or 10
- ☐ Beck Screeners
- ☐ Other _____
- ☐ Not documented

Was a substance use screening done during the visit: `clear`
- ○ Yes
- ○ No
- ○ Not documented

Type of substance use screening performed: (check all that apply) `clear`
- ☐ NIDA Quick Screen V1.0 and NIDA ASSIST V2.0 Drug Abuse Screening Test (DAST-10)
- ☐ MAST
- ☐ Triage Assessment for Addictive Disorders (TAAD) CAGE
- ☐ UNCOPE
- ☐ CRAFFT
- ☐ Other _____
- ☐ Not documented

Specify substance(s) used: (check all that apply) `clear all`

☐ No documented history of substance abuse

Substance:	Results of screening:	Referral date for services:		Treatment Status:	Result of referral:
☐ Alcohol	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Marijuana (including synthetic versions)	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Non-medical/recreational Benzodiazepines (including Xanax, Valium, Librium, Ativan, etc.)	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Cocaine	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Crack	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Hallucinogens	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Heroin	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Ketamine/ecstasy/club drugs	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Prescription opioids	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Methamphetamine/Amphetamine	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼
☐ Other _____	Select ▼	Date: mm/dd/yyyy ☐ Not applicable/ not documented		Select ▼	Select ▼

Treatment modality: (check all that apply) `clear`

☐ Medication-Assisted Treatment (MAT)
☐ Detox
☐ Acupuncture
☐ Licensed counselor
☐ Peer support staff
☐ narcotics Anonymous (NA)
☐ Alcoholics Anonymous (AA)
☐ Halfway/Sober House
☐ Counseled by provider
☐ Syringe services
☐ Other _____
☐ Not documented

Current Medication Assisted Treatment (MAT) use: `clear`

○ Yes ○ No ○ Unknown

Type of Medication Assisted Treatment (MAT): `clear`

○ Buprenorphine/ Naloxone (Suboxone)
○ Buprenorphine
○ Oral Naltrexone
○ Long acting injectable Naltrexone
○ Methadone
○ Disulfiram
○ Acamprosate
○ Other _____
○ Not documented

Administration of NARCAN to patient: `clear`

○ Yes ○ No ○ Not documented

Specify tobacco/nicotine usage: (check all that apply) `clear all`

☐ No documented history of tobacco/nicotine use

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Specify tobacco/nicotine usage: (check all that apply) `clear all`

☐ No documented history of tobacco/nicotine use

Type of tobacco:	History:	Cessation counseling at visit:	Treatment Status:
☐ Cigarettes	Select ▼	Select ▼	Select ▼
☐ Cigar/Cigarillo	Select ▼	Select ▼	Select ▼
☐ Vaporizer	Select ▼	Select ▼	Select ▼
☐ Snuff	Select ▼	Select ▼	Select ▼
☐ Other [____]	Select ▼	Select ▼	Select ▼

Tobacco/nicotine medication used by patient: (check all that apply) `clear`

☐ Nicotine patch ☐ Nicotine gum ☐ Chantix ☐ Wellbutrin ☐ Not documented

HCV treatment status: (check all that apply) `clear`

☐ In treatment ☐ Completed treatment ☐ Incomplete treatment ☐ Not documented/Not applicable

Co-morbid conditions during the review period: (Type ahead) `clear`

[Type co-morbities]

7. Medications Screen

All Medications prescribed, including ART regimen: ▼

Medication Name:
[_____]

Enter 99 in place of an unknown month or day, ex: 99-99-2019

Start date: [mm-dd-yyyy] ☐ Not documented

Stop date: [mm-dd-yyyy] ☐ Not documented

[+]

8. Lab Testing Screen

CD4 Count #1 ▼

Date: [mm/dd/yyyy] ☐ Not documented   Result: [_____] mm³ = µL   and [_____] %

☐ Not documented   ☐ Not documented

[Add Another CD4 Count]

Viral Load #1 ▼

Date: [mm/dd/yyyy] ☐ Not documented   Result: [Select ▼] [_____] copies/mL ☐ Not documented

[Add Another Viral Load]

Glucose Regulation Test #1 ▼

Date: [mm/dd/yyyy] ☐ Not documented   Type: ☐ Hemoglobin A1c
Result: [_____] %   ☐ Not documented

[Add Another Glucose Test]

Lipid Level Test #1

Date: mm/dd/yyyy ☐ Not documented   clear all

Cholesterol HDL: [　　　　] mg/dL ☐ Not documented   Cholesterol LDL: [　　　　] mg/dL ☐ Not documented

Cholesterol Total: [　　　　] mg/dL ☐ Not documented   Triglycerides: [　　　　] mg/dL ☐ Not documented

Add Another Lipid Test

Chem panels - Chemistry #1

Date: mm/dd/yyyy   ☐ Not documented

Add Another Chem Panel

TB screening Test #1

Date: mm/dd/yyyy   clear all   ☐ Not documented ☐ Not applicable, patient has a history of TB or a history of a (+) PPD result or IGRA test

Type: ☐ PPD ☐ IGRA ☐ Chest X-ray ☐ Not documented

Result: ☐ Positive ☐ Negative ☐ Indeterminate (for IGRA) ☐ Not documented

Add another Test

Colorectal cancer screening

Date: mm/dd/yyyy ☐ Not documented

Type: clear

◯ Stool test ◯ Flexible sigmoidoscopy ◯ Colonoscopy ◯ CT colonograph/virtual colonoscopy ◯ Not documented

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Women's health screening ▼

Pregnancy test: [clear]   Date: [mm/dd/yyyy]   ☐ Not documented   [+]

HPV screening: [clear]   Date: [mm/dd/yyyy]   ☐ Not documented   [+]

Results of HPV screening test: ○ Detected ○ Not detected ○ Not documented

Cervical PAP Smear: [clear]   Date: [mm/dd/yyyy]   ☐ Not documented ☐ Not applicable (form women with hysterectomy without residual cervix)   [+]

Results of Cervical PAP Smear: ○ Unsatisfactory ○ Nilm (negative for intraepithelial lesion or malignancy) ○ Ascus (atypical squamous cells of undetermined significance) ○ Lgsil (low grade squamous intraepithelial lesion)
○ AGC ○ ASC-H (atypical squamous cells, cannot exclude high grade) ○ Hgsil (high grade squamous intraepithelial lesion) ○ No result listed

Colposcopy: [clear]   Date: [mm/dd/yyyy]   ☐ Not documented ☐ Hysterectomy non-cancerous   [+]
     Referral Date: [mm/dd/yyyy]   ☐ Not documented (If a result is indicated without a screening date)

Breast cancer screening: [clear]   Date: [mm/dd/yyyy]   ☐ Not documented   [+]
     Breast cancer screening type: ☐ Mammogram ☐ MRI ☐ Not documented

Bone density test: [clear]   Date: [mm/dd/yyyy]   ☐ Not documented   [+]

Hepatitis A screen ever since diagnosis #1 ▼

Hepatitis A IgG screening date: [mm/dd/yyyy] ☐ Not documented   [clear all]

Hepatitis A IgG screening results: ☐ Positive ☐ Negative ☐ Not documented

Total antibody (IgM and IgG) screening date: [mm/dd/yyyy] ☐ Not documented

Total antibody (IgM and IgG) screening results: ☐ Positive ☐ Negative ☐ Not documented

[Add Another Hepatitis A Screen]

Hepatitis B screen ever since diagnosis #1 ▼

HBV surface antibody screening date: [mm/dd/yyyy] ☐ Not documented   [clear all]

HBV surface antibody results: ☐ Positive ☐ Negative ☐ Not documented

HBV core antibody screening date: [mm/dd/yyyy] ☐ Not documented

HBV core antibody results: ☐ Positive ☐ Negative ☐ Not documented

HBV surface antigen screening date: [mm/dd/yyyy] ☐ Not documented

HBV surface antigen results: ☐ Positive ☐ Negative ☐ Not documented

HBV DNA screening date: [mm/dd/yyyy] ☐ Not documented

HBV DNA results: [Select ▼] International units/mL ☐ Not documented

[Add Another Hepatitis B Screen]

Hepatitis C screen ever since diagnosis #1 ⌄

HCV screening date: [mm/dd/yyyy] ☐ Not documented   [clear all]

HCV screening test type: ☐ HCV antibody test ☐ HCV RNA test ☐ Not documented

HCV antibody test results: ☐ Positive ☐ Negative ☐ Not documented

HCV RNA test results: Values copies/ml [   ] ☐ Detectable ☐ Below Detectable Limits ☐ Negative ☐ Not documented

HCV genotyping test date: [mm/dd/yyyy] ☐ Not documented

HCV genotyping test results: ☐ Genotype 1 ☐ Genotype 2 ☐ Genotype 3 ☐ Genotype 4 ☐ Genotype 5 ☐ Not documented

[Add Another Hepatitis C Screen during the review period]

Liver disease Test #1 ⌄

Liver test date: [mm/dd/yyyy] ☐ Not documented   [clear all]

Test type:

Liver Biopsy: ☐ Liver biopsy

Liver Imaging: ○ Fibroscan (Transient Elastography)
                                                                ○ Acoustic radiation force impulse (ARFI) Acuson S2000
                                                                ○ Real-time tissue elastography (RTE) HI VISION, Preirus
                                                                ○ Magnetic Resonance Elastography

Serum Liver Biomarkers: ○ Fibrotest
                                                                ○ ActiTest
                                                                ○ Hepascore
                                                                ○ Fibrospect II
                                                                ○ European Liver Fibrosis Panel
                                                                ○ AST/ALT Ratio (hand calculated)
                                                                ○ AST and Platelet with APRI (Lab test)
                                                                ○ AST: platelet ratio (hand calculated)

[Add Another Liver disease Test]

STI screen during the review period #1 ⌄

                                              [clear all]

Syphilis screening date: [mm/dd/yyyy] ☐ Not documented

Syphilis results: ☐ Reactive ☐ Non-reactive ☐ Not documented

Chlamydia screening date: [mm/dd/yyyy] ☐ Not documented

Chlamydia screening site: ☐ Throat ☐ Anal/rectal ☐ Vaginal ☐ Urine ☐ Not documented

Chlamydia results: ☐ Positive ☐ Negative ☐ Not documented

Gonorrhea screening date: [mm/dd/yyyy] ☐ Not documented

Gonorrhea results: ☐ Positive ☐ Negative ☐ Not documented

Gonorrhea screening site: ☐ Throat ☐ Anal/rectal ☐ Vaginal ☐ Urine ☐ Not documented

Gonorrhea type of specimen: ☐ Nucleic acid amplification test (NAAT) ☐ Culture ☐ Not documented

[Add Another STI Screen]

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9. Vaccines Screen

Hepatitis A vaccine #1

Dose 1 date: mm/dd/yyyy   ☐ Not documented

Dose 2 date: mm/dd/yyyy   ☐ Not documented

Add Another Hepatitis A

Hepatitis B vaccine #1

Dose 1 type: clear all

Select Vaccine ▼

Dose 1 date: mm/dd/yyyy   ☐ Not documented

Dose 2 type:

Select Vaccine ▼

Dose 2 date: mm/dd/yyyy   ☐ Not documented

Dose 3 type:

Select Vaccine ▼

Dose 3 date: mm/dd/yyyy   ☐ Not documented

Add Another Hepatitis B

Hepatitis A and B vaccine #1 ▾

Dose 1 type:

Select Vaccine ▾   clear all

Dose 1 date: mm/dd/yyyy   ☐ Not documented

Dose 2 type:

Select Vaccine ▾

Dose 2 date: mm/dd/yyyy   ☐ Not documented

Dose 3 type:

Select Vaccine ▾

Dose 3 date: mm/dd/yyyy   ☐ Not documented

Add Another Hepatitis A and B

Influenza vaccine #1 ▾

Date: mm/dd/yyyy   ☐ Not documented

Add Another Influenza

Remarks ▾