

Ryan White Program Data Report and Quality Management
Medical Providers Data Collection Form
Reporting Period January – December 2008

(Note: Medical Providers and Providers that pay for Medical Care should track and input this data for QM.)

Last Name _____ **First Name** _____ **MI** _____
(Name Not reported in client level data. For internal use only)

Date of Birth _____ **Client ID** _____

Gender Male Female Transgender Unknown/Unreported

Status Active Inactive Deceased

If Deceased, **Date of Death** _____

Race (check all that apply)

- White
- Black or African American
- Asian
- Native Hawaiian/Pacific Islander
- American Indian or Alaskan Native
- Unknown/Unreported

Ethnicity (check only one)

- Hispanic or Latino/a
- Not Hispanic or Latino/a
- Unknown

HIV Status (check only one)

- HIV-positive not AIDS
- HIV-positive, AIDS status unknown
- HIV Indeterminate (under age 2 only)
- CDC-defined AIDS
- HIV-negative (affected)
- Unknown/Unreported

HIV Risk Factors (check all that apply)

- Men who have sex with men (MSM)
- Injection drug user (IDU)
- Hemophilia/coagulation disorder
- Heterosexual contact
- Blood Transfusion or Tissue
- Perinatal transmission
- Other
- Undetermined/Unknown/Not reported

If AIDS, Date AIDS Diagnosis: _____

Monthly Household Income _____

Size of Household _____

Housing/Living Arrangement (check only one)

- Permanently Housed
- Non-permanently Housed
- Institution
- Other
- Unknown/Unreported

Medical Insurance (check only one)

- Private
- Medicare
- Medicaid
- Other Public
- No Insurance
- Unknown/unreported

Screening/Testing for Any of the Following:

HIV (Western Blot, Elysa, etc.) Most Recent Date _____ Positive/Negative
Syphilis Most Recent Date _____ Positive/Negative
STIs other than Syphilis and HIV Most Recent Date _____ Positive/Negative
Hepatitis C Most Recent Date _____ Positive/Negative
Hepatitis B Most Recent Date _____ Positive/Negative

Tuberculosis

Screening/Testing

Was TB Skin Test Medically Indicated This Year? ___ Yes ___ No
If Yes, Was TB Skin Test Performed This Year? ___ Yes ___ No
If Yes, Date TB Skin Test Performed: _____
TB Skin Test Result: Positive Negative Client Did Not Return for Reading

Prophylaxis/Treatment:

TB Treatment Date _____ Drug _____
TB Treatment Completed? Date _____
TB Prophylaxis Date _____ Drug _____
TB Prophylaxis Completed? Date _____
Is this treatment /prophylaxis for Active or Latent TB Infection? Active ___ Latent ___

Procedures

Pelvic Exam Date(s) _____
Pap Smear Date(s) _____

Prescriptions to Treat any of the following:

Syphilis Date _____ Drug _____
Start Date _____ End Date _____

STIs other than Syphilis and HIV Date _____ Drug _____
Start Date _____ End Date _____

Hepatitis C Date _____ Drug _____
Start Date _____ End Date _____

Antiretroviral Therapy (Select Current Therapy) Current Antiretroviral Prescribed

None _____ Drug _____
Mono or Dual _____ Drug _____
HAART _____ Drug _____
Salvage _____ Drug _____

Date first prescribed antiretrovirals _____ Date antiretrovirals ended _____

If no, antiretrovirals prescribed, reason not prescribed: *not clinically necessary, patient refused, other* (please specify): _____

Diagnosis (This year)

Pneumocystis jirovecii Pneumonia (PCP)	Date(s) _____
Mycobacterium Avium Complex (MAC)	Date(s) _____
Mycobacterium Tuberculosis (TB)	Date(s) _____
Cytomegalovirus	Date(s) _____
Toxoplasmosis	Date(s) _____
Cervical Cancer	Date(s) _____
Other AIDS-Defining Conditions	Date(s) _____

CD4 Tests

Date _____	Result _____

Viral Load Tests

Date _____	Result _____

Pregnancy Information (document any pregnancy during the year)

Date Became	Date Ended	Live Birth?	Child HIV+?	Child Gender	Antiretrovirals Prescribed?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Service Grid:

Service Grid/Initial Service Information:

Service Type	Date of Visit/Service	Date of Visit/Service	Date of Visit/Service	Date of Visit/Service	Date of Visit/Service
Medical Care					
Case Management Medical					
Case Management Non-medical					

Adherence Counseling					
Risk Reduction					
HIV Knowledge Test					
Oral Health Care					

PHS Standards

1. Has this patient been prescribed HAART in the reporting period? (HAART is a **specified** combination of ARVs as defined by PHS guidelines. Not all combinations of ARVs are considered HAART.)? ___ Yes ___ No

1a. If yes, date HAART Started _____ Date HAART ended _____

1b. If no, reason not prescribed: *not clinically necessary, patient refused, other* (please specify):

2. Did this patient have a CD4 below 200 during this reporting period?

2a. If Yes, was the patient prescribed PCP Prophylaxis? _____
Date Prescribed? _____ Name of Drug? _____

3. Did this patient have a CD4 below 50 (or age adjusted for risk as clinically indicated for children) in the reporting period?

3a. If Yes, was the patient prescribed MAC Prophylaxis?
Date Prescribed? _____ Name of Drug? _____

4. Does this patient have Hepatitis B immunity at the time of data collection? ___ Yes ___ No

4a. If No, was a vaccine series completed? ___ Yes ___ No

4b. Reason Series Not Completed: *Patient Refused, Allergies, Other* _____

Medical Provider Name: _____

Date: _____