eHIVQUAL

Manual Data Collection Form

ADULT (over 13 years old by beginning of review period) PATIENT PROFILE

All Indicators

Note: To ensure that you only need to refer to each patient's medical chart once, please make sure to answer all of the *applicable* follow-up questions on this form. Shaded questions represent optional fields within required indicators.

REVIEW PERIOD: _____

NB: ALL REVIEWS FOR SUBMISSION TO THE AIDS INSTITUTE RUN FROM ***JANUARY 1ST*** *THROUGH* ***DECEMBER 31ST***

1. PATIENT DEMOGRAPHIC INFORMATION (Required for All Programs)

LAST NAME:						
FIRST NAME:						
MIDDLE INITIAL (OPTIONAL):						
MEDICAL RECORD #						
GENDER:		FEMALE		TRANSGENDER: MALE TO FEMALE		
		MALE		TRANSGENDER: FEMALE TO MALE		
		IF FEMALE-TO-MALE TRANSGENDERED PATIENT, BIOLOGICAL CERVIX?			Y	N
DATE OF BIRTH: / / (FOUR DIGIT YEAR)						
RACE/ETHNICITY:		WHITE, NON-HISPANIC/LATINO				
		BLACK, NON-HISPANIC/LATINO				
		HISPANIC				
		ASIAN				
		AMERICAN INDIAN/ALASKA NATIVE				
		NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER				
		MORE THAN ONE RACE OR ETHNICITY				
EXPOSURE CATEGORY		INJECTING DRUG USER (IDU)				
		HEMOPHILIA/COAGULATION DISORDER				
		PERINATAL TRANSMISSION				
		HETEROSEXUAL				
		TRANSFUSION/BLOOD COMPONENTS				
		HETEROSEXUAL & IDU				
		MEN WHO HAVE SEX WITH MEN (MSM)				
		MSM & IDU				
		OTHER				
		UNKNOWN				
PRIMARY PAYOR (REQUIRED IN NYS; OPTIONAL OUTSIDE NYS):		MEDICAID FEE-FOR-SERVICE		FAMILY HEALTH PLUS		
		MEDICAID MANAGED CARE		CHILD HEALTH PLUS		
		MEDICAID SPECIAL NEEDS PLAN (NYC ONLY)		PRIVATE MANAGED CARE OR COMMERCIAL COVERAGE		
		MEDICARE FEE-FOR-SERVICE		WORKER'S COMP OR NO-FAULT		
		MEDICARE MANAGED CARE		CORRECTIONS		
		SELF-PAY		VETERAN'S ADMINISTRATION		
		ADAP OR ADAP+		OTHER		
		MEDICAID AND MEDICARE		UNKNOWN		
PRIMARY PAYOR NUMBER (OPTIONAL):						
PROVIDER (MD/NP) (OPTIONAL):						

2. VISITS (Required for All Programs)

NEW PATIENT (NEVER SEEN IN THE CLINIC BEFORE THE BEGINNING OF THE REVIEW PERIOD)?		Y	N
IF YES, ENTER DATE WHEN HIV+ DIAGNOSIS WAS CONFIRMED:			
DATE:	UNKNOWN DATE		
	IF THIS DATE WAS DURING REVIEW PERIOD, DID THE PATIENT SUBSEQUENTLY HAVE A CLINICAL DIAGNOSIS OF AIDS DURING THE REVIEW PERIOD?	Y	N
		N/A	

FOR ALL PATIENTS, LIST ALL VISITS DURING THE REVIEW PERIOD WITH A PRIMARY CARE PROVIDER:

VISIT DATE	VISIT DATE	VISIT DATE	VISIT DATE

IF FEMALE, WAS THE PATIENT PREGNANT DURING THE REVIEW PERIOD?	Y	N	N/A
IF YES, ESTIMATED/ACTUAL DELIVERY DATE:			

3. HIV MONITORING (Required for All Programs)

ENTER ALL CD4 RESULTS OBTAINED DURING THE REVIEW PERIOD		ENTER ALL VIRAL LOAD RESULTS OBTAINED DURING THE REVIEW PERIOD				
DATE ("Reported Date")	CD4 COUNT	DATE ("Reported Date")	REPORTED AS			VL Value
			<	=	>	
			<	=	>	
			<	=	>	
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4. ARV MEDICATIONS (Required for All Programs)

HAD THE PATIENT EVER BEEN ON ART BEFORE THE BEGINNING OF THE REVIEW PERIOD?	Y	N

GIVE THE START AND STOP DATES FOR EACH ARV MEDICATION THE PATIENT WAS ON DURING THE REVIEW PERIOD

INCLUDE ALL MEDICATIONS THE PATIENT WAS ON AT THE START OF THE PERIOD. IF A MEDICATION WAS STOPPED, GIVE THE DATE STOPPED.

IF MEDICATION WAS BEGUN PRIOR TO THE REVIEW PERIOD AND YOU DO NOT KNOW THE START DATE, YOU CAN USE ANY DATE BEFORE THE REVIEW PERIOD AS THE 1ST START DATE (FOR EXAMPLE, ENTER 12/31/10 FOR MEDICATION PRESCRIBED BEFORE THE 2011 REVIEW PEIROD).

MEDICATION		1ST START	1ST STOP	2ND START	2ND STOP
ABACAVIR (ZIAGEN)	ABC				
ABACAVIR/LAMIVUDINE (EPZICOM)	ABC/3TC				
ATAZANAVIR (REATAZ)	ATV				
CLINICAL TRIAL (Deprecated - Please Specify Drug)	CLINTRIAL				
DARUNAVIR (PREZISTA)	DRV				
DELAVIRDINE (RESCRIPTOR)	DLV				
DIDANOSINE (VIDEX)	DDI				
DIDEOXYCYTIDINE (ZALCITABINE)	DDC				
EFAVIRENZ (SUSTIVA)	EFV				
EMTRICITABINE (EMTRIVA)	FTC				
EMTRICITABINE/RIPLIVIRINE/TENOFOVIR (COMPLERA)	FTC/RPV/TDF				
EMTRICITABINE/TENOFOVIR/EFAVIRENZ (ATRIPLA)	FTC/TDF/EFV				
ENFUVIRTIDE (FUZEON)	T-20 OR ENF				
ETRAVIRINE (INTELENCE)	ETR				
FOSAMPRENAVIR (LEXIVA)	FPV				
INDINAVIR (CRIXIVAN)	IDV				
LAMIVUDINE (EPIVIR)	3TC				
LOPINAVIR/RITONAVIR (KALETRA)	LPV/r				
MARAVIROC (SELZENTRY)	MVC				
NELFINAVIR (VIRACEPT)	NFV				
NEVIRAPINE (VIRAMUNE)	NVP				
OTHER	OTH				
RALTEGRAVIR (ISENTRESS)	RAL				
RILPILVIRINE (EDURANT)	RPV				
RITONAVIR (NORVIR)	RTV				
SAQUINAVIR (INVIRASE, FORTAVASE)	SQV				
STAVUDINE (ZERIT)	D4T				
TENOFOVIR/EMTRICITABINE (TRUVADA)	TDF/FTC				
TENOFOVIR (VIREAD)	TDF				
TIPRANAVIR (APTIVUS)	TPV				
ZIDOVUDINE (RETORVIR)	ZDV OR AZT				
ZIDOVUDINE/LAMIVUDINE (COMBIVIR)	ZDV/3TC				
ZIDOVUDINE/LAMIVUDINE/ABACAVIR (TRIZIVIR)	ZDV/3TC/ABC				

5. ADHERENCE ASSESSMENT (Required for All Programs)

WAS THE PATIENT EVER ON AN ARV DRUG DURING THE REVIEW PERIOD?					Y	N
IF YES, WAS THE PATIENT'S ADHERENCE ASSESSED DURING THE REVIEW PERIOD?					Y	N
IF YES	WAS ADHERENCE ASSESSMENT		QUANTITATIVE		QUALITATIVE	
	IF QUANTITATIVE, WHAT WAS THE PERCENTAGE?					
	IF QUALITATIVE, WHAT WAS THE LEVEL (EXCELLENT, GOOD, FAIR, OR POOR)?					
	WAS AN ADHERENCE PROBLEM IDENTIFIED?				Y	N
	IF YES, WAS THE ADHERENCE PROBLEM ADDRESSED?				Y	N

6. PCP PROPHYLAXIS (Required for All Programs)

THIS INDICATOR DOES NOT APPLY IF (1) THERE WERE NO CD4 COUNTS BELOW 200 DURING THE REVIEW PERIOD OR (2) IF ALL OF THE FOLLOWING OCCURRED DURING THE REVIEW PERIOD:

A) THERE WAS EXACTLY ONE CD4 COUNT BELOW 200

B) THAT CD4 COUNT OCCURRED DURING THE FIRST SIX MONTHS OF THE REVIEW PERIOD

C) THERE WAS AT LEAST ONE SUBSEQUENT CD4 >= 200 DURING THE REVIEW PERIOD

OTHERWISE, ENTER THE FIRST DATE DURING THE REVIEW PERIOD WHEN PCP PROPHYLAXIS WAS PRESCRIBED:	NOT APPLICABLE
	NONE DOCUMENTED

IF PCP PROPHYLAXIS WAS PRESCRIBED:

	WHICH MEDICATION?		TMP/SULFA (BACTRIM)			DAPSONE		ATAVAQUONE		OTHER

7. MAC PROPHYLAXIS (Optional for All Programs)

THIS INDICATOR DOES NOT APPLY IF (1) THERE WERE NO CD4 COUNTS BELOW 50 DURING THE REVIEW PERIOD OR (2) IF ALL OF THE FOLLOWING OCCURRED DURING THE REVIEW PERIOD:

A) THERE WAS EXACTLY ONE CD4 COUNT BELOW 50

B) THAT CD4 COUNT OCCURRED DURING THE FIRST SIX MONTHS OF THE REVIEW PERIOD

C) THERE WAS AT LEAST ONE SUBSEQUENT CD4 >= 200 DURING THE REVIEW PERIOD

OTHERWISE, ENTER THE FIRST DATE DURING THE REVIEW PERIOD WHEN MAC PROPHYLAXIS WAS PRESCRIBED:	NOT APPLICABLE
	NONE DOCUMENTED

IF MAC PROPHYLAXIS WAS PRESCRIBED:

	WHICH MEDICATION?		CLARITHOMYCIN		RIFABUTIN	AZITHROMYCIN		OTHER

8. BASELINE RESISTANCE TEST (Required for All Part C/D Programs; Optional for non-C/D NYS Programs)

IF THE PATIENT BEGAN ARV THERAPY FOR THE FIRST TIME DURING THE REVIEW PERIOD, *AND* HAD A VL GREATER THAN 1000 DURING THE REVIEW PERIOD (PRIOR TO ART INITIATION), ENTER DATE OF MOST RECENT GENOTYPIC RESISTANCE TEST PERFORMED PRIOR TO ART INITIATION:	NOT APPLICABLE
	NONE DOCUMENTED

9. SUBSTANCE USE SCREENING (Required for All Programs, Except Drug Treatment Centers)

WAS SUBSTANCE USE DISCUSSED DURING THE REVIEW PERIOD?			Y / N
IF YES, WAS SUBSTANCE USE IDENTIFIED?	Y, CURRENTLY (WITHIN LAST 6 MONTHS)	Y, PAST ONLY	
	NOT DOCUMENTED	NONE	

CURRENT							PAST
MARK ALL SUBSTANCES USED AND, IF APPLICABLE, THE WAY USED: (AT LEAST ONE SUBSTANCE MUST BE SPECIFIED)							WHEN WAS THE LAST TIME SUBSTANCES WERE USED?
HEROIN		INJECTED		INTRANASAL		SMOKED	
COCAINE		INJECTED		INTRANASAL		SMOKED	6-12 MONTHS BEFORE ASSESSMENT
	IF HEROIN AND/OR COCAINE INJECTED, WAS SAFER INJECTION/SYRINGE EXCHANGE ADDRESSED?					Y / N	12-24 MONTHS BEFORE ASSESSMENT
ALCOHOL	INHALANTS (GLUE, NITROUS)		ECTSTASY	HALLUCINOGENS			
BENZODIAZEPINES	KEATAMINE	CRYSTAL METHAMPHETAMINE					MORE THAN 24 MONTHS BEFORE ASSESSMENT
PRESCRIPTION OPIOIDS (VICODIN, CODEINE)		AMPHETAMINES					
OTHER SUBSTANCE:							
WAS THE PATIENT IN TREATMENT DURING THE REVIEW PERIOD?						Y / N	IF BETWEEN 6-24 MONTHS, WAS RELAPSE PREVENTION OR ONGOING TREATMENT INDICATED BASED ON PAST SUBSTANCE USE HISTORY?
IF YES, CIRCLE ALL THAT APPLY (MUST SPECIFY AT LEAST 1)							
DETOXIFICATION UNIT	METHADONE	RESIDENTIAL TREATMENT					
OUTPATIENT NON-METHADONE		12-STEP SELF HELP					
HARM REDUCTION		BUPRENOPHRINE					Y / N
IF NO, CIRCLE ONE OF THE FOLLOWING:							IF YES, WAS RELAPSE PREVENTION OR ONGOING TREATMENT DISCUSSED?
DISCUSSED/REFERRAL NOT INDICATED		REFERRAL MADE		NOT ADDRESSED			
IF REFERRED, CIRCLE ALL THAT APPLY (SPECIFY AT LEAST 1)							
DETOXIFICATION UNIT	METHADONE	RESIDENTIAL TREATMENT					
OUTPATIENT NON-METHADONE		12-STEP SELF HELP					
HARM REDUCTION		BUPRENOPHRINE					Y / N

IF SUBSTANCE USE WAS NOT DISCUSSED, WAS IT IDENTIFIED AS AN EXPOSURE RISK AT BASELINE?	Y / N

10. MENTAL HEALTH SCREENING (Required for All Programs)

ENTER DATE OF LAST DEPRESSION SCREEN DURING REVIEW PERIOD:				
			NONE DOCUMENTED	
IF SCREENED, WAS TREATMENT FOR DEPRESSION INDICATED?			Y	N
IF TREATMENT INDICATED:				
	ALREADY RECEIVING CARE	TREATMENT PROVIDED	REFERRAL INDICATED	
IF REFERRAL INDICATED, ENTER DATE OF LAST REFERRAL:				
			NONE DOCUMENTED	
IF REFERRAL WAS MADE, WAS PATIENT SEEN WITHIN 30 DAYS?			Y	N
ENTER DATE OF LAST ANXIETY SCREEN DURING REVIEW PERIOD:				
			NONE DOCUMENTED	
IF SCREENED, WAS TREATMENT FOR ANXIETY INDICATED?			Y	N
IF TREATMENT INDICATED:				
	ALREADY RECEIVING CARE	TREATMENT PROVIDED	REFERRAL INDICATED	
IF REFERRAL INDICATED, ENTER DATE OF LAST REFERRAL:				
			NONE DOCUMENTED	
IF REFERRAL WAS MADE, WAS PATIENT SEEN WITHIN 30 DAYS?			Y	N
ENTER DATE OF LAST PTSD SCREEN DURING REVIEW PERIOD:				
			NONE DOCUMENTED	
IF SCREENED, WAS TREATMENT FOR PTSD INDICATED?			Y	N
IF TREATMENT INDICATED:				
	ALREADY RECEIVING CARE	TREATMENT PROVIDED	REFERRAL INDICATED	
IF REFERRAL INDICATED, ENTER DATE OF LAST REFERRAL:				
			NONE DOCUMENTED	
IF REFERRAL WAS MADE, WAS PATIENT SEEN WITHIN 30 DAYS?			Y	N
ENTER DATE OF LAST COGNITIVE FUNCTION ASSESSMENT (INCLUDING MENTAL STATUS) DURING REVIEW PERIOD:				
			NONE DOCUMENTED	
IF SCREENED, WAS TREATMENT FOR COGNITIVE FUNCTION INDICATED?			Y	N
IF TREATMENT INDICATED:				
	ALREADY RECEIVING CARE	TREATMENT PROVIDED	REFERRAL INDICATED	
IF REFERRAL INDICATED, ENTER DATE OF LAST REFERRAL:				
			NONE DOCUMENTED	
IF REFERRAL WAS MADE, WAS PATIENT SEEN WITHIN 30 DAYS?			Y	N
SLEEPING HABITS ASSESSMENT DONE?			Y	N
APPETITE ASSESSMENT DONE?			Y	N
DOMESTIC VIOLENCE SCREENING DONE?			Y	N

11. LIPID SCREENING (Required for All Programs)

MOST RECENT DATE OF MOST RECENT LIPID PROFILE THAT INCLUDED TRIGLYCERIDE, CHOLESTEROL AND HDL LEVELS (DURING THE REVIEW PERIOD)		
	DATE:	NONE DOCUMENTED
	IF DATE ENTERED, ENTER THE LDL LEVEL IF THIS WAS REPORTED ON THAT PROFILE:	

12. TOBACCO USE SCREENING (Required for All Programs)

MOST RECENT TOBACCO USE DISCUSSION (DURING THE REVIEW PERIOD)			
	DATE:	NONE DOCUMENTED	
	IF DISCUSSED DURING REVIEW PERIOD, WAS THE PATIENT A TOBACCO SMOKER?	Y	N
	IF YES, MOST RECENT SMOKING CESSATION DISCUSSION (DURING THE REVIEW PERIOD)		
	DATE:	NONE DOCUMENTED	

13. COLON CANCER SCREENING (Required for All NYS Programs; Optional for Programs Outside NYS)

IF THE PATIENT IS OVER 50, HAS A COLONOSCOPY BEEN PERFORMED IN THE LAST TEN YEARS? IF SO, WHAT WAS THE DATE (IF KNOWN)?	Y	N	N/A	

14. PNEUMOCOCCAL VACCINATION (Required for All Programs)

MOST RECENT PNEUMOCOCCAL VACCINATION (DURING OR PRIOR TO REVIEW PERIOD)		
	DATE:	NONE DOCUMENTED

15. INFLUENZA VACCINATION (Required for All Programs)

MOST RECENT INFLUENZA VACCINATION (DURING THE REVIEW PERIOD)		
	DATE:	NONE DOCUMENTED

16. ORAL HEALTH EXAM (Required for All Programs)

WAS AN ORAL HEALTH EXAM PERFORMED DURING THE REVIEW PERIOD BY AN ORAL HEALTH PROVIDER?	Y	N

17. URINALYSIS (Required for All Programs)

MOST RECENT LABORATORY URINALYSIS (PERFORMED DURING THE REVIEW PERIOD)		
	DATE:	NONE DOCUMENTED

18. CERVICAL PAP EXAM (Required for All Programs)

MOST RECENT CERVICAL PAP EXAM (PERFORMED DURING OR PRIOR TO THE REVIEW PERIOD) [REQUIRED FOR FEMALES; OPTIONAL FOR F->M TRANSGENDER WITH BIOLOGICAL CERVIX]		N/A (MALE)	
	DATE:	NONE DOCUMENTED	
	IF A PAP EXAM WAS PERFORMED, WAS THE RESULT ABNORMAL?	Y	N
	IF YES, WAS THERE A SECOND CERVICAL PAP OR A GYN REFERRAL?	Y	N
	IF YES, WAS A DIAGNOSIS OBTAINED?	Y	N
	IF YES, WAS CERVICAL CANCER DIAGNOSED?	Y	N

19. MAMMOGRAPHY (Required for All NYS Programs; Optional for Programs Outside NYS)

FOR WOMEN > 40, MOST RECENT MAMMOGRAPHY EXAM (PERFROMED DURING OR PRIOR TO REVIEW PERIOD)		
	DATE:	NONE DOCUMENTED

20. ANORECTAL EXAM (Required for All Part C/D Programs; Optional for non-C/D NYS Programs)

MOST RECENT ANORECTAL EXAM (DURING THE REVIEW PERIOD)		
	DATE:	NONE DOCUMENTED

21. ANAL PAP SMEAR (Optional for All Programs)

DOES THE PATIENT HAVE A DOCUMENTED HISTORY OF ANOGENITAL HPV INFECTION?		Y	N
IF YES, OR IF THE PATIENT IS MSM, OR A FEMALE WHO HAD AN ABNORMAL VAGINAL PAP SMEAR DURING THE REVIEW PERIOD:			
	DID THE PATIENT HAVE AN ANAL PAP SMEAR DURING THE REVIEW PERIOD?	Y	N	N/A

22. LATENT TB INFECTION SCREENING (Required for All Part C/D Programs; Optional for non-C/D NYS Programs)

WAS THE PATIENT KNOWN TO HAVE A POSITIVE TEST FOR LATENT TB INFECTION BEFORE THE REVIEW PERIOD OR KNOWN TO HAVE BEEN TREATED FOR ACTIVE TB?			Y	N
	IF NO, HAS THE PATIENT BEEN TESTED FOR TB WHILE RECEIVING CARE AT YOUR FACILITY?	Y N	TESTED BUT RESULT NOT KNOWN	
IF YES	WHEN WAS THE MOST RECENT TEST (PPD READ OR OTHER TB TEST RESULT)?			
	WHAT KIND OF TEST WAS PERFORMED?		PPD	OTHER
	WHAT WAS THE RESULT?		NEG	POS

23. HEPATITIS C SCREENING AND MANAGEMENT (Required for All Programs)

WHAT WAS THE PATIENT'S HEPATITIS C ANTIBODY STATUS AT THE START OF THE REVIEW PERIOD?

(A) UNKNOWN	(B) NEGATIVE	(C) POSITIVE
WHAT WAS THE PATIENT'S HEPATITIS C ANTIBODY STATUS AT THE END OF THE REVIEW PERIOD?	ENTER DATE OF LAST SCREEN *PRIOR* TO THE REVIEW PERIOD:	WHAT WAS THE STATUS OF THE PATIENT'S LAST KNOWN RNA ASSAY?
UNKNOWN (GO TO C)	WAS THE PATIENT AT HIGH RISK OF INFECTION DURING THE REVIEW PERIOD (ACTIVE IDU, MULTIPLE SEXUAL PARTNERS, MSM SEX WITHOUT BARRIER PROTECTION OR NEW ABNORMAL LFTs)? Y N	NONE DOCUMENTED
NEGATIVE (STOP)		NEGATIVE
POSITIVE TEST OBTAINED BEFORE OCTOBER 1ST (GO TO C)		POSITIVE
POSITIVE TEST OBTAINED ON OR AFTER OCTOBER 1ST (GO TO C)	IF YES, WAS THE PATIENT RETESTED DURING THE REVIEW PERIOD? Y N	IF POSITIVE, WAS FURTHER TREATMENT OR EVALUATION DISCUSSED DURING THE REVIEW PERIOD? Y N

24. SEXUAL ACTIVITY SCREENING (Required for All Programs)

WAS THE PATIENT ASSESSED FOR SEXUAL ACTIVITY DURING THE REVIEW PERIOD?			Y	N	UNKNOWN
	IF YES, WAS THE PATIENT SEXUALLY ACTIVE DURING THE REVIEW PERIOD		Y	N	UNKNOWN
		IF YES, ANSWER EACH OF THE FOLLOWING QUESTIONS:			
		DID THE PATIENT HAVE VAGINAL INTERCOURSE DURING THE REVIEW PERIOD?	Y	N	UNKNOWN
		DID THE PATIENT HAVE ORAL INTERCOURSE DURING THE REVIEW PERIOD?	Y	N	UNKNOWN
		DID THE PATIENT HAVE ANAL INTERCOURSE DURING THE REVIEW PERIOD?	Y	N	UNKNOWN

25. STI SCREENING (Required for All Programs)

WAS SERUM SYPHILIS SCREENING (RPR OR VDRL) PERFORMED DURING THE REVIEW PERIOD)?				Y	N
	IF YES, WAS THE RESULT POSITIVE?			Y	N
	IF YES, WAS THIS A NEW INFECTION?		NOT SURE	Y	N
	IF YES OR NOT SURE, WAS THE PATIENT TREATED?			Y	N
WAS A URINE, URETHRAL (M) OR CERVICAL (F) GONORRHEA TEST PERFORMED DURING THE REVIEW PERIOD?				Y	N
	IF YES, WAS THE RESULT POSITIVE?			Y	N
		IF YES, WAS THE INFECTION TREATED?		Y	N
WAS A PHARYNGEAL GONORRHEA TEST PERFORMED DURING THE REVIEW PERIOD?				Y	N
	IF YES	WHAT TYPE OF TEST WAS PERFOMED?	NUCLEIC ACID TEST	CULTURE	
		WAS THE RESULT POSITIVE?		Y	N
		IF YES, WAS THE INFECTION TREATED?		Y	N

WAS A RECTAL GONORRHEA TEST PERFORMED DURING THE REVIEW PERIOD?				Y	N
	IF YES	WHAT TYPE OF TEST WAS PERFOMED?	NUCLEIC ACID TEST	CULTURE	
		WAS THE RESULT POSITIVE?		Y	N
		IF YES, WAS THE INFECTION TREATED?		Y	N
WAS A URINE, URETHRAL (M) OR CERVICAL (F) CHLAMYDIA TEST PERFORMED DURING THE REVIEW PERIOD?				Y	N
	IF YES, WAS THE RESULT POSITIVE?			Y	N
		IF YES, WAS THE INFECTION TREATED?		Y	N
WAS A PHARYNGEAL CHLAMYDIA TEST PERFORMED DURING THE REVIEW PERIOD?				Y	N
	IF YES	WHAT TYPE OF TEST WAS PERFOMED?	NUCLEIC ACID TEST	CULTURE	
		WAS THE RESULT POSITIVE?		Y	N
		IF YES, WAS THE INFECTION TREATED?		Y	N
WAS A RECTAL CHLAMYDIA TEST PERFORMED DURING THE REVIEW PERIOD?				Y	N
	IF YES	WHAT TYPE OF TEST WAS PERFOMED?	NUCLEIC ACID TEST	CULTURE	
		WAS THE RESULT POSITIVE?		Y	N
		IF YES, WAS THE INFECTION TREATED?		Y	N

26. DIABETES SCREENING & MANAGEMENT (Required for All Programs)

WAS A FASTING BLOOD GLUCOSE LEVEL (FBS) OBTAINED DURING THE REVIEW PERIOD?				Y	N
	IF YES	MOST RECENT DATE:	VALUE:		
WAS AN ORAL GLUCOSE TOLERANCE TEST (OGTT) CONDUCTED DURING THE REVIEW PERIOD?				Y	N
	IF YES	MOST RECENT DATE:	VALUE:		
WAS AN HBA1C TEST PERFORMED DURING THE REVIEW PERIOD?				Y	N
	IF YES	MOST RECENT DATE:	VALUE: %		
WERE **ANY** OF THESE THESHOLD VALUES MET OR EXCEEDED? (a) FBS >= 126 (b) OGTT >= 200 (c) HBA1C >= 6.5%				Y	N
	IF YES	WAS SERUM CREATININE MEASURED?		Y	N
		IF YES:	MOST RECENT DATE:	VALUE:	
		WAS A RETINAL EXAM PERFORMED?		Y	N

27. HYPERTENSION SCREENING & MANAGEMENT (Required for All Programs)

WHEN WAS THE PATIENT'S LAST BLOOD PRESSURE READING (DURING THE REVIEW PERIOD)?					
WHAT WAS THE VALUE?					
WAS THE PATIENT BEING TREATED FOR HYPERTENSION?				Y	N
IF TREATED	BASED ON ABOVE VALUE, WAS THE PATIENT STAGE 2 HYPERTENSIVE (SYSTOLIC >= 160 OR DIASTOLIC >= 100)?			Y	N
	IF NOT STAGE 2, WAS THE PATIENT STAGE 1 HYPERTENSIVE (NOT STAGE 2, SYSTOLIC >= 140 OR DIASTOLIC >= 90)?			Y	N
	IF THE PATIENT WAS STAGE 1: WAS THE PATIENT TREATED WITH MEDICATION?	Y	N	NO, BUT LIFESTYLE MODIFICATION PLANNED	
	IF THE PATIENT WAS STAGE 2: WAS THE PATIENT TREATED WITH A 2-DRUG COMBINATION?			Y	N

28. PATIENT EDUCATION (Optional for All Programs)

MOST RECENT GENERAL HIV EDUCATION (DURING THE REVIEW PERIOD)		
	DATE:	NONE DOCUMENTED

29. PREVENTION EDUCATION (Required for All NYS Programs; Optional for Programs Outside NYS)

DID THE PATIENT RECEIVE PREVENTION EDUCATION DURING THE FIRST SIX MONTHS OF THE REVIEW PERIOD (JANUARY 1ST TO JUNE 30TH)?	Y	N
DID THE PATIENT RECEIVE PREVENTION EDUCATION DURING THE FINAL SIX MONTHS OF THE REVIEW PERIOD (JULY 1ST TO DECEMBER 31ST)?	Y	N

30. HEALTH LITERACY (Required for All NYS Programs; Optional for Programs Outside NYS)

WAS THE PATIENT SCREENED AT LEAST ONCE FOR HEALTH LITERACY WHILE RECEIVING HIV CARE AT YOUR FACILITY?		Y	N
WAS THE NEED FOR A HEALTH LITERACY INTERVENTION DOCUMENTED DURING THE 12-MONTH REVIEW PERIOD?		Y	N
	IF A NEED WAS IDENTIFIED, WAS A HEALTH LITERACY INTERVENTION IMPLEMENTED DURING THE 12-MONTH REVIEW PERIOD?	Y	N

31. CARE COORDINATION (Required for All Programs)

WAS THE PATIENT ASKED ABOUT HIS/HER USE OF SUPPORT SERVICES (E.G., CASE MANAGEMENT, HOUSING ASSISTANCE, MENTAL HEALTH TREATMENT, SUBSTANCE USE TREATMENT) DURING THE REVIEW PERIOD?				Y	N
IF NO	IS THERE DOCUMENTATION THAT THE PATIENT RECEIVED SUPPORT SERVICES AT ANOTHER AGENCY DURING THE REVIEW PERIOD?		YES -> CONTINUE TO LIST OF SERVICES		
			NO -> STOP		
IF YES	DID THE PATIENT RECEIVE SUPPORT SERVICES AT ANOTHER AGENCY DURING THE REVIEW PERIOD?	YES -> CONTINUE TO LIST OF SERVICES			
		NO -> STOP			
		NOT DOCUMENTED -> STOP			
LIST OF SERVICES	CASE MANAGEMENT?			Y	N
		IF YES, IS THERE A RECORD OF APPROPRIATE CONTACT INFORMATION FOR THIS SERVICE?		Y	N
	MENTAL HEALTH?			Y	N
		IF YES, IS THERE A RECORD OF APPROPRIATE CONTACT INFORMATION FOR THIS SERVICE?		Y	N
	SUBSTANCE USE?			Y	N
		IF YES, IS THERE A RECORD OF APPROPRIATE CONTACT INFORMATION FOR THIS SERVICE?		Y	N
	TREATMENT ADHERENCE?			Y	N
		IF YES, IS THERE A RECORD OF APPROPRIATE CONTACT INFORMATION FOR THIS SERVICE?		Y	N
	OTHER SERVICE?			Y	N
	IF YES	PLEASE SPECIFY:			
		IS THERE A RECORD OF APPROPRIATE CONTACT INFORMATION FOR THIS SERVICE?		Y	N
CARE PLAN	DOCUMENTATION OF PATIENT PARTICIPATION DURING THE REVIEW PERIOD IN THE CREATION, UPDATE, OR DOCUMENTATION OF A CARE COORDINATION PLAN?			Y	N
	IF YES	DID THIS OCCUR AT LEAST ONCE IN EACH HALF OF THE REVIEW PERIOD, AT LEAST 60 DAYS APART?		Y	N
		DID THE PATIENT REVIEW AND SIGN THE CARE COORDINATION PLAN OR UPDATE?		Y	N
		WAS THE PATIENT GIVEN A COPY OF THE CARE COORDINATION PLAN OR UPDATE?		Y	N
		OTHER PARTICIPATION IN CARE COORDINATION PLAN?		Y	N
			IF YES, PLEAS SPECIFY:		
	DOCUMENTATION OF PATIENT PARTICIPATION DURING THE REVIEW PERIOD IN A CASE CONFERENCE ABOUT HIS OR HER CARE COORDINATION?			Y	N
		IF YES, DID THIS OCCUR AT LEAST ONCE IN EACH HALF OF THE REVIEW PERIOD, AT LEAST 60 DAYS APART?		Y	N
	DOCUMENTATION OF OTHER DISCUSSION WITH THE PATIENT DURING THE REVIEW PERIOD ABOUT COORDINATION OF CARE?			Y	N
		IF YES, DID THIS OCCUR AT LEAST ONCE IN EACH HALF OF THE REVIEW PERIOD, AT LEAST 60 DAYS APART?		Y	N
	DOCUMENTATION OF OTHER PATIENT PARTICIPATION IN COORDINATION OF CARE DURING THE REVIEW PERIOD?			Y	N
		IF YES	PLEASE SPECIFY:		
			DID THIS OCCUR AT LEAST ONCE IN EACH HALF OF THE REVIEW PERIOD, AT LEAST 60 DAYS APART?	Y	N