LSOCA

Enrollment Form

Purpose: To record enrollment data.

When: Prior to enrolling a patient. FAX (410-955-0932) to CC upon completion of enrollment procedures. All procedures (including consent) should be completed within 10 days prior to enrollment.

By whom: Clinic coordinator.

A. Clinic, patient and visit identification

1. Clinic ID code: ____ ____ ____ ____

2. Patient ID#: ____ ____ ____ ____

3. Patient name code: ____ ____ ____ ____ ____

4. Date of enrollment:

____ ____–____ ____ ____–____ ____
day mon year

5. Visit ID code: B L ____

B. Inclusion criteria

6. Diagnosis of AIDS according to current Centers for Disease Control and Prevention (CDC) definition:

( ) Yes (1) ( ) No (2)
STOP

7. Age 13 or over:

( ) Yes (1) ( ) No (2)
STOP

8. Did the patient (or legal representative) sign and date the consent form:

( ) Yes (1) ( ) No (2)
STOP

9. Date patient (or legal representative) signed and dated the consent/assent form:

____ ____–____ ____ ____–____ ____
day mon year

10. Patient consented to having specimens banked for research:

( ) Yes (1) ( ) No (2)

(If No, do not collect blood for specimen banking.)

11. Has the patient been diagnosed with an ocular opportunistic infection:

( ) Yes (1) ( ) No (2)
12.

a. Date of diagnosis of ocular opportunistic infection:

____ ____–____ ____ ____–____ ____
day mon year

b. Is the date of diagnosis of the ocular opportunistic infection within 45 days (inclusive) of the date of enrollment:

( ) Yes (1) ( ) No (2)
14.

Note: If "Yes", the patient's ocular opportunistic infection is defined as newly diagnosed and therefore will NOT be counted towards the enrollment quota. If "No", the patient's ocular opportunistic infection is defined as longstanding and will be counted toward the enrollment quota.

12. Date of diagnosis of AIDS:

____ ____ ____–____ ____
month year

List date first diagnosed with AIDS from subitem 20c. on the Baseline History form.

13. Is date of diagnosis of AIDS on or after January 2001:

( ) Yes (1) ( ) No (2)
STOP

Patient ID#: ____ ____ ____ ____

14. Type of ocular opportunistic infection *(as obtained from the Eye Exam form at Baseline); (check all that apply)*

a. CMV retinitis: (1)
b. Herpetic retinitis: (1)
c. Toxoplasmic retinitis: (1)
d. Cryptococcal choroidopathy: (1)
e. Pneumocystis or other choroidopathy: (1)
f. No ocular opportunistic infection: (1)

C. Baseline procedures

All procedures must be completed before enrollment.

15. Have the following baseline procedures been completed

	Yes	No
a. Hematology/Serum chemistry:	(1)	(2)
b. Lymphocyte analysis:	(1)	(2)
c. Fundus photography:	(1)	(2)
d. Eye history:	(1)	(2)
e. Medical history:	(1)	(2)
f. Treatment history:	(1)	(2)
g. Quality of life:	(1)	(2)
h. Visual functioning questionnaire - 25:	(1)	(2)
i. Eye exam:	(1)	(2)
j. Visual acuity with refraction:	(1)	(2)
k. Contrast sensitivity: *(If Pelli-Robson chart is available)*	(1)	(2)
l. Automated perimetry:	(1)	(2)
m. Goldmann visual field:	(1)	(2)
n. Blood collected for banking:	(1)	(2)
o. Patient location form:	(1)	(2)
p. Antiretroviral Treatment History form:	(1)	(2)
q. Cardiovascular/Cerebrovascular Risk Profile form:	(1)	(2)

D. Administrative information

16. Date form reviewed:

____ ____–____ ____ ____–____ ____
day mon year

17. Clinic coordinator ID: ____ ____

18. Clinic coordinator signature:

_____

Item #19 should be completed by satellite clinics only. Record clinic ID code followed by the satellite clinic number (e.g. USF1). First satellite clinic number should be 1; Code additional satellite clinics sequentially.

19. Satellite clinic ID:

____ ____ ____ ____ ____