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

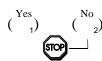
- **1.** Clinic ID code: ____ ___ ___
- 2. Patient ID#:
- **3.** Patient name code: ____ ___ ____
- **4.** Date of enrollment:

day	mon	year

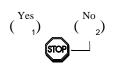
- **5.** Visit ID code:
- <u>B</u> <u>L</u> ___

B. Inclusion criteria

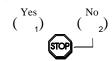
6. Diagnosis of AIDS according to current Centers for Disease Control and Prevention (CDC) definition:



7. Age 13 or over:



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



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

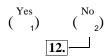
day mon year

10. Patient consented to having specimens banked for research:

 $\binom{\text{Yes}}{1}$ $\binom{\text{No}}{2}$

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

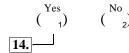
11. Has the patient been diagnosed with an ocular opportunistic infection:



a. Date of diagnosis of ocular opportunistic infection:

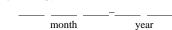


b. Is the date of diagnosis of the ocular opportunistic infection within 45 days (inclusive) of the date of enrollment:



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:



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:



1 of 2

(as obtained from the Eye Exam fo (check all that apply)	rm at Baselii	ne);
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 complete		

D. Administrative information

6.	Date	form	review	/ed:	

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:		

•	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	n:(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/Cerebrovas	cula	r		

Risk Profile form: (1)