LSOCA

Patient Location Information

> **Purpose:** To record patient contact information. For confidential use only. Do not send to Coordinating Center.
> **Instructions:** Complete a PL form every 6 months.

A. Clinic, patient and visit identification

1. Patient ID code: ⎯⎯ ⎯⎯ ⎯⎯ ⎯⎯

2. Patient name code: ⎯⎯ ⎯⎯ ⎯⎯ ⎯⎯ ⎯⎯

3. ACTG Patient ID# *(if applicable):*

⎯⎯ ⎯⎯ **-** ⎯⎯ ⎯⎯ ⎯⎯ ⎯⎯
ACTG ID#

4. ACTG Institution *(if applicable):*

_____
institution name

B. Personal data

5. Date patient location information collected:

⎯⎯ ⎯⎯ - ⎯⎯ ⎯⎯ - ⎯⎯ ⎯⎯
day   mon   year

6. Name:

_____
last name, first name, middle initial

_____
maiden name (if applicable)

_____
other name(s) used (if applicable)

7. Social security number:

_____

8. Date of birth:

⎯⎯ ⎯⎯ - ⎯⎯ ⎯⎯ - ⎯⎯ ⎯⎯
day   mon   year

9. Place of birth:

_____
city, state or province

_____
country

10. Home address and telephone number:

_____
number and street (apartment# if applicable)

_____
city and state or province, country, zipcode

_____
(area code) daytime telephone number

_____
(area code) evening telephone number

11. Email address:

_____
email address

12. Father's name:

_____
last name, first name, middle initial

13. Mother's name:

_____
last name, first name, middle initial

14. Mother's maiden name:

_____
last name, first name, middle initial

C. Patient contacts
(provide the names and addresses of people to contact should the need arise)

15. Currently employed:

(Yes 1)   (No 2)

18. ⎯⎯

16. Employer:

_____
name of employer

_____
name of company

_____
employer's address / number and street

_____
city and state or province, country, zipcode

17. Work telephone number:

_____
(area code) telephone number

18. Referring physician:

_____
last name, first name

_____
number and street

_____
city and state or province, country, zipcode

_____
(area code) telephone number

19. Primary physician:

_____
last name, first name

_____
number and street

_____
city and state or province, country, zipcode

_____
(area code) telephone number

20. Friend, family member or social worker
to contact in case of an emergency

a. Name:

_____
last name, first name

b. Relationship to patient:

_____

c. Home/office address and telephone
number:

_____
number and street (apartment number if applicable)

_____
city and state or province, country, zipcode

_____
(area code) telephone number

21. Friend, family member or social worker
to contact in case of an emergency

a. Name:

_____
last name, first name

b. Relationship to patient:

_____

c. Home/office address and telephone
number:

_____
number and street (apartment number if applicable)

_____
city and state or province, country, zipcode

_____
(area code) telephone number

22. Friend, family member or social worker
to contact in case of an emergency

a. Name:

_____
last name, first name

b. Relationship to patient:

_____

c. Home/office address and telephone
number:

_____
number and street (apartment number if applicable)

_____
city and state or province, country, zipcode

_____
(area code) telephone number