

NIDA Clinical Trials Network

Adverse Events (AD1)

Web Version: 1.0; 5.00; 07-26-12

Adverse Event Onset Date (AEDATE):
Select Sequence Number (AESEQNUM):

Record only the adverse events associated with events directly related to the collection of blood samples.

1. Adverse event name:(A1DESCR1)

2. Date site became aware of the event:(A1AWARDT)

 (mm/dd/yyyy) [Click here to view calendar](#)

3. Severity of event:(A1SEVR2)

4. Is there a reasonable possibility that the intervention caused the event? (A1REL TIN)

☐ No ☐ Yes

If "Unrelated" to study intervention, alternative etiology:(A1ALTEB)

If "Other," specify:(A1AEBSP)

5. Action taken with study intervention:(A1ACTBI)

6. Outcome of event:(A1OUTCM)

7. Date of resolution or medically stable:(A1RESDT)

 (mm/dd/yyyy)

Except for "None of the following" and "Hospitalization for a medical event", all selections in the question below will designate this as a Serious Adverse Event (SAE). The Serious Adverse Event Summary (AD2) form should be completed for all Serious Adverse Events reported.

8. Was this event associated with: (A1ASSOC2)

If "Death", date of death: (A1DTHDTE)

(mm/dd/yyyy)

9. If "Inpatient admission to hospital" or "Prolongation of hospitalization":

Date of hospital admission: (A1HOSPAD)

(mm/dd/yyyy)

Date of hospital discharge: (A1HOSPCD)

(mm/dd/yyyy)

Comments: (A1COMM)

MedDRA:

The following fields are auto-populated by the DSC2 based on MedDRA coding of the Adverse Event name.

Preferred Term: (MEDRAPT)

Not Coded

System Organ Class: (MEDRASOC)

Additional Selection Options for AD1

Select Sequence Number (*ASEQNUM*) (key field):

- 01 -1st Adverse Event of the day
- 02 -2nd Adverse Event of the day
- 03 -3rd Adverse Event of the day
- 04 -4th Adverse Event of the day
- 05 -5th Adverse Event of the day
- 06 -6th Adverse Event of the day
- 07 -7th Adverse Event of the day
- 08 -8th Adverse Event of the day
- 09 -9th Adverse Event of the day
- 10 -10th Adverse Event of the day
-

Action taken with study intervention:

- 5-Participant terminated from study

Was this event associated with:

- 5-Prolongation of hospitalization
- 6-Persistent or significant incapacity
- 7-Congenital anomaly or birth defect
- 8-Important medical event that required intervention to prevent any of the above

NIDA Clinical Trials Network

Serious Adverse Event Summary (AD2)

Web Version: 1.0; 1.00; 03-09-12

Adverse Event Onset Date (AEDATE):
Select Sequence Number (AESEQNUM):

1. Initial narrative description of serious adverse event:

(A2SUMM)

2. Relevant Past Medical History: (A2SAEMHX) ☐ No ☐ Yes ☐ Unknown

Allergies, pregnancy, smoking and alcohol use, hypertension, diabetes, epilepsy, depression, etc.

(A2MEDHX)

3. Medications at the Time of the Event: (A2SAEMED) ☐ No ☐ Yes ☐ Unknown

Medication (Generic Name)	Indication
(A2_01DNM) <input type="text"/>	(A2_01DIN) <input type="text"/>
(A2_02DNM) <input type="text"/>	(A2_02DIN) <input type="text"/>
(A2_03DNM) <input type="text"/>	(A2_03DIN) <input type="text"/>
(A2_04DNM) <input type="text"/>	(A2_04DIN) <input type="text"/>
(A2_05DNM) <input type="text"/>	(A2_05DIN) <input type="text"/>

(A2_06DNM)		(A2_06DIN)	
(A2_07DNM)		(A2_07DIN)	
(A2_08DNM)		(A2_08DIN)	
(A2_09DNM)		(A2_09DIN)	
(A2_10DNM)		(A2_10DIN)	

4. Treatments for the Event: (A2SAETRT) ☐ No ☐ Yes ☐ Unknown

T treatment	Indication	Date T reated
(A2_1TNME)	(A2_1TIND)	(A2_1L TDT) (mm/dd/yyyy)
(A2_2TNME)	(A2_2TIND)	(A2_2L TDT) (mm/dd/yyyy)
(A2_3TNME)	(A2_3TIND)	(A2_3L TDT) (mm/dd/yyyy)
(A2_4TNME)	(A2_4TIND)	(A2_4L TDT) (mm/dd/yyyy)
(A2_5TNME)	(A2_5TIND)	(A2_5L TDT) (mm/dd/yyyy)

5. Labs/Tests Performed in Conjunction with this Event: (A2SAELAB) ☐ No ☐ Yes ☐ Unknown

Lab/T est	Findings	Date of Test
(A2_1LBNM)	(A2_1LBIN)	(A2_1LBDT) (mm/dd/yyyy)
(A2_2LBNM)	(A2_2LBIN)	(A2_2LBDT) (mm/dd/yyyy)
(A2_3LBNM)	(A2_3LBIN)	(A2_3LBDT) (mm/dd/yyyy)
(A2_4LBNM)	(A2_4LBIN)	(A2_4LBDT) (mm/dd/yyyy)
(A2_5LBNM)	(A2_5LBIN)	(A2_5LBDT) (mm/dd/yyyy)

6. Follow-Up:

Include labs/test results as they become available, clinical changes, consultant diagnosis, etc.

(A2FOLLUP)

7. Additional information requested by the Medical Monitor:

(A2ADDINF)

Have all Medical Monitor requests been addressed?(A2RQADDR)

☐ Yes

Additional Selection Options for AD2

Select Sequence Number (*ASEQNUM*) (key field):

- 01 -1st Adverse Event of the day
- 02 -2nd Adverse Event of the day
- 03 -3rd Adverse Event of the day
- 04 -4th Adverse Event of the day
- 05 -5th Adverse Event of the day
- 06 -6th Adverse Event of the day
- 07 -7th Adverse Event of the day
- 08 -8th Adverse Event of the day
- 09 -9th Adverse Event of the day
- 10 -10th Adverse Event of the day
-

NIDA Clinical Trials Network

Serious Adverse Event Medical Reviewer (AD3)

Web Version: 1.0; 3.00; 03-09-12

Adverse Event Onset Date (AEDATE):
Select Sequence Number (AESEQNUM):

1. Was this determined to be a serious adverse event? (A3DETER)
2. Was this event considered associated with the study's behavioral intervention? (A3BHINT)
3. Was this event expected? (A3EXPECT)
4. Is this a standard expedited/reportable event? (i.e., is it serious, unexpected and related to therapy) (A3EXPFDA)
5. Is this an expedited/reportable event for other reasons? (A3EXPOTH)
6. Does the protocol need to be modified based on this event? (A3EXPDSM)
7. Does the consent form need to be modified based on this event? (A3CONSEN)
8. Is the review complete? (A3REVDNE)
If "No", what additional information is required: (A3ADDINF)

- | | |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Assessed by: (A2ASRID)

Reviewed by: (A3REVID)

Comments: (A3COMM)

- | | |
|--|--|
| <input type="checkbox"/> Robert Lindblad | <input type="checkbox"/> Radhika Kondapaka |
| <input type="checkbox"/> Robert Lindblad | |

Additional Selection Options for AD3

Select Sequence Number (*ASEQNUM*) (key field):

- 01 -1st Adverse Event of the day
- 02 -2nd Adverse Event of the day
- 03 -3rd Adverse Event of the day
- 04 -4th Adverse Event of the day
- 05 -5th Adverse Event of the day
- 06 -6th Adverse Event of the day
- 07 -7th Adverse Event of the day
- 08 -8th Adverse Event of the day
- 09 -9th Adverse Event of the day
- 10 -10th Adverse Event of the day
-

NIDA Clinical Trials Network

Additional Demographics (ADE)

Web Version: 1.0; 5.00; 04-05-13

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Date of assessment: (*ADEASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

1. Is this the first time that you have been interviewed by someone on our staff to see if you are eligible to participate in this study? (*AD1STINT*)

a. What was the outcome of the last time you spoke to us about the study? (*ADINTOUT*)

b. What happened the last time you spoke to us about the study? (*ADINTCOM*)

2. What is your gender? (*ADGENDER*)

a. Some of our participants identify themselves as "transgender." Does this apply to you? (*ADTRANS*)

☐ No ☐ Yes

b. What was your sex assigned at birth? (*ADBIRTHS*)

☐ Male ☐ Female

c. Have you had sex reassignment surgery? (*ADSEXSUR*)

☐ No ☐ Yes

3. What is the highest grade or level of school you have completed, or the highest degree you have received? (*ADEDUCAT*)

4. What is your marital status? (*ADMARRIE*)

5. We would like to know about what you do - are you working now, looking for work, retired, keeping house, a student, or what?(ADWORKIN)

If "Other," specify:(ADWORKOT)

a. What kind of paid work do you do?

Provide detail that describes the activity or skill required by the job, and if it involves management of others. For example, rather than "construction" we'd like "bricklayer"; rather than "metal-worker" we'd like welder; rather than "restaurant" we'd like "wait-person in a restaurant"; rather than "health care" we'd like "medical assistant" or "phlebotomist"; rather than "hair salon" we'd like "hairstylist" or "manicurist." (ADKINDWK)

b. Regardless of full-time or part-time status, how many hours per week on average do you work?(ADWRHRWK)

Hours: (xx)

c. What is your current wage for this job?(ADWAGEHR)

Hourly: (xxx.xx) -or- (ADWAGEYR)Annual: (xxx,xxx)

6. What was your total personal income in the last year from all sources?(ADINCPER)

(xxxxxx) (ADPIDKRF) ☐ Don't know ☐ Refuse to answer

If income is greater than \$999,995 enter 999,995;

Which of the following is the category that your total personal income from all sources would be in?(ADINCPRW)

7. What is your best estimate of the total income of all family members from all legal sources, before taxes, in last calendar year?(ADINCFAM)

(xxxxxx) (ADTIDKRF) ☐ Don't know ☐ Refuse to answer

If income is greater than \$999,995 enter 999,995;

Which of the following is the category that your total family income from legal sources would be in?(ADINCFMW)

Note that the participant's personal income should be included in total income.

8. Are you covered by health insurance or some other kind of health care plan?(ADHLTINS)

What kind of health insurance or health care coverage do you have?

Include those that pay for only one type of service (such as nursing home care, accidents, or dental care). Exclude private plans that only provide extra cash while hospitalized. If you have more than one kind of health insurance, tell me all plans that you have.

a. Private health insurance(ADPRIHEA)

☐ No ☐ Yes

b. Medicare(ADMEDCAR)

☐ No ☐ Yes

c. Medi-gap (ADMEDIGA)

☐ No ☐ Yes

d. Medicaid(ADMEDCAD)

☐ No ☐ Yes

State plan name:(ADMEDSTA)

e. SCHIP (CHIP/children's health insurance program)(ADSCHIP)

☐ No ☐ Yes

f. Military health care (Tricare/VA/champ-VA) (ADMILTAR)

g. Indian health service (ADINDIAN)

h. State-sponsored health plan (ADSTATES)

i. Other government program (ADGOVOTH)

j. Single service plan (e.g., dental, vision, prescriptions) (ADSINGLE)

k. ADAP (ADADAP)

l. Other insurance (ADINSOTH)

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

State plan name: (ADSTATSP)

Specify "Other insurance": (ADINOTSP)

9. Have you ever been in jail, prison, or a correctional facility? (ADJAIL)

a. In the last 6 months, have you ever been in jail, prison, or a correctional facility? (AD6MJAIL)

b. In the past 6 months, how many days have you spent in jail, prison, or a correctional facility?

If the participant provides a response in months,

the number of days should be calculated with 1 month = 30 days (ADJAILY)

☐ No ☐ Yes

☐ No ☐ Yes

(xxx)

10. Which of the following best describes your Hispanic ethnic background? (ADHSBGD)

If "Other", specify: (ADHSOTH)

11. Which of the following best describes your Asian ethnic background? (ADASBGD)

If "Other", specify: (ADASIOTH)

12. Which of the following best describes your Black ethnic background? (ADBKBGD)

If "Other," specify: (ADBKBGOT)

13. Over the past 4 weeks, which of the following describes the amount of food you have had available to eat? (ADFDEAT)

Number of days in the previous 4 weeks with no food or money to buy food?(ADFDMON)

14. In what country were you born?(ADCOUNTR)

Is English your second language?(ADENG2LA)

☐ No ☐ Yes

15. If you are enrolled in this study, will you be living in the vicinity and able to return to this site for a follow-up visit in 12-16 months from today?(ADLIVVIC)

☐ No ☐ Yes

16. Would you be able to understand an interviewer or counselor talking in English?(ADUNDERS)
Interviewer endorsement of ability to communicate in English:(ADENDORS)

☐ No ☐ Yes

☐ No ☐ Yes

Instruct the participant to "Think about where you were living immediately before being admitted to this hospital. How long have you lived in this area?"

17. During the past six months, where did you live or sleep most of the time?(ADLIVSLP)

If "Other," specify:(ADOTSLEP)

18. In the last 6 months, indicate all the places you have lived.

	No	Yes	Don't Know	Refuse to Answer	Not Applicable
a. Homeless (living on the street, in a park, in a bus station, etc.)	(ADHOMELE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In a shelter	(ADSHELTE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Transitional (time - limited) single - room occupancy hotel	(ADTRANSI) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Permanent single - room occupancy hotel	(ADPERMAN) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. HIV/AIDS housing/group home	(ADGROUP) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Drug treatment facility	(ADDRUGTX) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other residential facility or institution (e.g. health care facility, halfway house)	(ADRESOTH) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Staying with family/friends	(ADFAMILY) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Rent an apartment/house (alone or with others)	(ADRENT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Own my home	(ADOWNHOM) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

k. In Jail	(ADLVJAIL) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Other, specify:(ADLIOTSP) <input type="text"/>	(ADLIVEOT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. How long have you lived in this area (i.e., Zip Code)?(ADLIVLGT)

20. Who do you live with?

	No	Yes	Refuse to Answer
a. Alone	(ADALONE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Partner	(ADPARTNE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Parents	(ADPARENT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Children	(ADCHILDR) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other Family	(ADFAMOTH) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Friends	(ADFRIEND) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Roommates/housemates	(ADRMATE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Other, specify:(ADLVWTSP) <input type="text"/>	(ADWHOOTH) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Do you live with anyone who has a current alcohol problem?(ADLVALCH)

☐ No ☐ Yes

22. Do you live with anyone who uses illegal drugs or marijuana?(ADLVDRG)

☐ No ☐ Yes

23. Do you live with anyone who abuses prescription/OTC medications or other substances?(ADLVDRRX)

☐ No ☐ Yes

24. Do you have any children under the age of 18?(ADCHILD)

25. How many children under 18 do you have daily care and responsibility for?(ADRESPCA)

(xx)

26. Which year did you get your first positive test for HIV?(ADPOSYR)

(xxxx) (ADYRDKRF)-or- ☐ Don't know -or- ☐ Refuse to answer

Which month did you get your first positive test for HIV? (ADPOS MO)

27. Have you ever had HIV primary care?
By HIV primary care, we mean a clinician or team of clinicians who you see in a clinic or office on a regular basis and who works with you to manage your HIV/AIDS medications, blood test results, T - cell count and viral load. (ADHIVPR)

If "Yes", when was your last HIV primary care visit? (ADLASTVS)

28. Have you taken medications specifically for your HIV?
These would be antiretrovirals or a drug cocktail to reduce your viral load.
This means medications that attack HIV, not medications for other conditions. (ADHIVME)

29. Are you currently taking medications specifically for HIV? (ADTKEMED)

If "Yes," specify: (ADMEDSSP)

30. How many times have you been hospitalized in the last 12 months? (ADLSTHSP)
The number of hospitalizations entered should include the current hospitalization.
Of these, how many times have you been hospitalized in the last 6 months? (AD6M OHSP)

31. Have you ever participated in alcohol or drug treatment? (ADALDRTR)
a. In the past 12 months have you participated in alcohol or drug treatment? (AD12ALDR)
b. Were any of these treatments in the past 6 months? (AD06ALDR)

32. In the past 12 months, which of the following types of programs have you participated in?

	No	Yes
a. Drug free outpatient drug treatment	(AD12OUTP) <input type="checkbox"/>	<input type="checkbox"/>
b. Inpatient drug treatment	(AD12INPT) <input type="checkbox"/>	<input type="checkbox"/>
c. Methadone maintenance	(AD12METM) <input type="checkbox"/>	<input type="checkbox"/>
d. Buprenorphine treatment	(AD12BUPT) <input type="checkbox"/>	<input type="checkbox"/>

(xxx)

(xxx)

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

e. Detoxification	(AD12DET) <input type="checkbox"/>	<input type="checkbox"/>
f. Residential treatment program	(AD12RES) <input type="checkbox"/>	<input type="checkbox"/>
g. Alcoholics Anonymous (AA)	(AD12AA) <input type="checkbox"/>	<input type="checkbox"/>
h. Narcotics or Cocaine Anonymous (NA)	(AD12NCA) <input type="checkbox"/>	<input type="checkbox"/>
i. Other, specify:(AD12OTSP) <input type="text"/>	(AD12OTHE) <input type="checkbox"/>	<input type="checkbox"/>

Did you participate in any of these programs over the past 6 months?(AD06MOPR) ☐ No ☐ Yes

Comments:(ADECOMM)

Additional Selection Options for ADE

What is the highest grade or level of school you have completed, or the highest degree you have received?

- 6-Some college (4-year college or university)
- 7-College graduate (4-year college or university)
- 8-Graduate or professional school
- 98-Refused
- 97-Don't know

What is your marital status?

- 6-Living with partner
- 98-Refused
- 97-Don't know

We would like to know about what you do - are you working now, looking for work, retired, keeping house, a student, or what?

- 6-Unemployed, not looking for work
- 7-Retired
- 8-Disabled, permanently or temporarily
- 9-Unpaid child care or housework
- 10-Student
- 11-Currently incarcerated
- 99-Other

Which of the following is the category that your total personal income from all sources would be in?

- 6-\$30,001 to \$40,000
- 7-\$40,001 to \$50,000
- 8-More than \$50,000

Which of the following best describes your Hispanic ethnic background?

- 99-Other

Which of the following best describes your Asian ethnic background?

- 6-Indian
- 7-Pakistani
- 99-Other

Which of the following best describes your Black ethnic background?

- 6-African
- 99-Other

In what country were you born?

- 6-American Samoa
- 7-Andorra
- 8-Angola
- 9-Anguilla
- 10-Antarctica
- 11-Antigua & Barbuda
- 12-Antilles, Netherlands
- 13-Argentina
- 14-Armenia
- 15-Aruba
- 16-Australia
- 17-Austria
- 18-Azerbaijan
- 19-Bahamas, The
- 20-Bahrain
- 21-Bangladesh
- 22-Barbados
- 23-Belarus
- 24-Belgium
- 25-Belize
- 26-Benin
- 27-Bermuda
- 28-Bhutan
- 29-Bolivia
- 30-Bosnia & Herzegovina

31-Botswana
32-Bouvet Island
33-Brazil
34-British Indian Ocean Territory
35-British Virgin Islands
36-Brunei Darussalam
37-Bulgaria
38-Burkina Faso
39-Burundi
40-Cambodia
41-Cameroon
42-Canada
43-Cape Verde
44-Cayman Islands
45-Central African Republic
46-Chad
47-Chile
48-China
49-Christmas Island
50-Cocos (Keeling) Islands
51-Colombia
52-Comoros
53-Congo
54-Congo, Democratic Rep. of the
55-Cook Islands
56-Costa Rica
57-Cote D'Ivoire
58-Croatia
59-Cuba
60-Cyprus
61-Czech Republic
62-Denmark
63-Djibouti
64-Dominica
65-Dominican Republic
66-East Timor (Timor-Leste)
67-Ecuador
68-Egypt
69-El Salvador
70-Eritrea
71-Estonia
72-Ethiopia
73-European Union
74-Falkland Islands (Malvinas)
75-Faroe Islands
76-Fiji
77-Finland
78-France
79-French Guiana
80-French Polynesia
81-French Southern Territories - TF
82-Gabon
83-Gambia, The
84-Georgia
85-Germany
86-Ghana
87-Gibraltar
88-Greece
89-Greenland
90-Grenada
91-Guadeloupe
92-Guam
93-Guatemala
94-Guernsey & Alderney
95-Guinea

96-Guinea-Bissau
97 -Guinea, Equatorial
98 -Guiana, French
99-Guyana
100-Haiti
101-Heard and McDonald Islands
102-Holy See (Vatican City State)
103-Holland
104-Honduras
105-Hong Kong (China)
106-Hungary
107-Iceland
108-India
109-Indonesia
110-Iran , Islamic Republic of
111-Iraq
112-Ireland
113-Israel
114-Ivory Coast
115-Italy
116-Jamaica
117-Japan
118-Jersey
119-Jordan
120-Kazakhstan
121-Kenya
122-Kiribati
123-Korea, Demo. People's Rep. of
124-Korea, (South) Republic of
125-Kuwait
126-Kyrgyzstan
127-Lao People's Democratic Republic
128-Latvia
129-Lebanon
130-Lesotho
131-Liberia
132-Libyan Arab Jamahiriya
133-Liechtenstein
134-Lithuania
135-Luxembourg
136-Macao, (China)
137-Macedonia, TFYR
138-Madagascar
139-Malawi
140-Malaysia
141-Maldives
142-Mali
143-Malta
144-Man, Isle of
145-Marshall Islands
146-Martinique
147-Mauritania
148-Mauritius
149-Mayotte
150-Mexico
151-Micronesia, Federated States of
152-Moldova, Republic of
153-Monaco
154-Mongolia
155-Montenegro
156-Montserrat
157-Morocco
158-Mozambique
159-Myanmar (ex-Burma)
160-Namibia

161-Nauru
162-Nepal
163-Netherlands
164-Netherlands Antilles
165-New Caledonia
166-New Zealand
167-Nicaragua
168-Niger
169-Nigeria
170-Niue
171-Norfolk Island
172-Northern Mariana Islands
173-Norway
174-Oman
175-Pakistan
176-Palau
177-Palestinian Territory
178-Panama
179-Papua New Guinea
180-Paraguay
181-Peru
182-Philippines
183-Pitcairn Island
184-Poland
185-Portugal
186-Puerto Rico
187-Qatar
188-Reunion
189-Romania
190-Russia (Russian Federation)
191-Rwanda
192-Sahara
193-Saint Helena
194-Saint Kitts and Nevis
195-Saint Lucia
196-Saint Pierre and Miquelon
197-Saint Vincent and the Grenadines
198-Samoa
199-San Marino
200-Sao Tome and Principe
201-Saudi Arabia
202-Senegal
203-Serbia
204-Seychelles
205-Sierra Leone
206-Singapore
207-Slovakia
208-Slovenia
209-Soloman Islands
210-Somalia
211-South Africa
212-S. Georgia and S. Sandwich Island
213-Spain
214-Sri Lanka (ex-Ceilan)
215-Sudan
216-Suriname
217-Svalbard and Jan Mayen Islands
218-Swaziland
219-Sweden
220-Switzerland
221-Syrian Arab Republic
222-Taiwan
223-Tajikistan
224-Tanzania, United Republic of
225-Thailand

226-Timor-Leste (East Timor)
227-Togo
228-Tokelau
229-Tonga
230-Trinidad & Tobago
231-Tunisia
232-Turkey
233-Turkmenistan
234-Turks and Caicos Islands
235-Tuvalu
236-Uganda
237-Ukraine
238-United Arab Emirates
239-United Kingdom
240-Uruguay
241-Uzbekistan
242-Vanuatu
243-Vatican City State (Holy See)
244-Venezuela
245-Vietnam
246-Virgin Islands, British
247-Virgin Islands, U.S.
248-Wallis and Futuna
249-Western Sahara
250-Yemen
251-Zambia
252-Zimbabwe

During the past six months, where did you live or sleep most of the time?

6-Drug treatment facility
7-Other residential facility or institution (e.g., health care facility, halfway house)
8-Staying with family/friends
9-Rent an apartment/house (alone or with others)
10-Own my home
11-In jail
99-Other

How long have you lived in this area (i.e., Zip Code)?

98-Refuse to answer

Which month did you get your first positive test for HIV?

6-June
7-July
8-August
9-September
10-October
11-November
12-December
97-Don't know
98-Refuse to answer

If "Yes", when was your last HIV primary care visit?

98-Refuse to answer

NIDA Clinical Trials Network

Shortened HIV Adherence Measures (ADH)

Web Version: 1.0; 1.00; 07-10-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

The next questions are about your current/recently prescribed anti-HIV medications.

Date of assessment: (*ADHASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

1. Have you been prescribed any anti-HIV medications? (*ADHIVMED*)

☐ No ☐ Yes

Many patients find it difficult to take all their HIV medication exactly as prescribed.

2. How many doses of your HIV medication did you miss in the past 7 days? (*ADDOSMS*)

(xx)

3. Provide your best guess about what percentage of your prescribed HIV medication you have taken in the last month.

(xxx) %

It would be surprising if this was 100% for most people.

Examples: 0% means you have taken none of your medications in the last month, 50% means you have taken half of your medications in the last month and 100% means that you have taken every single dose of your medications. (ADDOSTKP)

4. Sometimes if you feel worse, do you stop taking your HIV medications? (*ADWORSE*)

☐ No ☐ Yes

5. Did you miss any of your HIV medications over the past weekend?

☐ No ☐ Yes

"Yes" means you missed meds

"No" means you did NOT miss meds (ADWKND)

*The following questions ask about symptoms you might have had during the **past month**. Choose the response/answer that describes how much you have been bothered by each symptom.*

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

6. Fatigue or loss of energy? (*ADENERGY*)

7. Fevers, chills or sweats? (*ADFEVER*)

8. Feeling dizzy or lightheaded? (*ADDIZZY*)

--

9. Pain, numbness or tingling in the hands or feet? (*ADNUMB*)

--

10. Trouble remembering? (*ADRMBER*)

--	--

11. Nausea or vomiting? (*ADVOMIT*)

--

12. Diarrhea or loose bowel movements? (ADBOWEL)

--

13. Felt sad, down or depressed? (ADSADEN)

--	--

14. Felt nervous or anxious? (*ADNERVES*)

15. Difficulty falling or staying asleep?(*ADSLEEP*)

--	--

16. Skin problems, such as rash, dryness or itching? *(ADSKNPRB)*

17. Cough or trouble catching your breath? *(ADCOUGH)*

18. Headache? *(ADHEDACH)*

19. Loss of appetite or change in the taste of food? *(ADAPETIT)*

20. Bloating, pain or gas in your stomach? *(ADBLOAT)*

21. Muscle aches or joint pain? *(ADM SACHE)*

22. Problems with having sex, such as loss of interest or lack of satisfaction? *(ADSEX)*

23. Changes in the way your body looks, such as fat deposits or weight gain?(*ADB DYCHG*)

24. Problems with weight loss or wasting?(*ADWEIGHT*)

25. Hair loss or changes in the way your hair looks? (*ADHAIRCG*)

Comments:(*ADHCOMM*)

NIDA Clinical Trials Network

Medication Adherence Self Efficacy (ADS)

Web Version: 1.0; 2.00; 07-01-13

Segment (*PROTSEG*):

Visit Number (VISNO):

Date of assessment: (ADSASMDT)

(mm/dd/yyyy) [Click here for calendar](#)

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

The next several questions are about your confidence with taking HIV medications. I will ask you to tell me in **the past month, including today**, how confident you have been that you can do the following things. Please respond on a scale of 0 to 10 where 0 = you cannot do at all, 5 = moderately (somewhat) certain you can do and 10 = completely certain you can do.

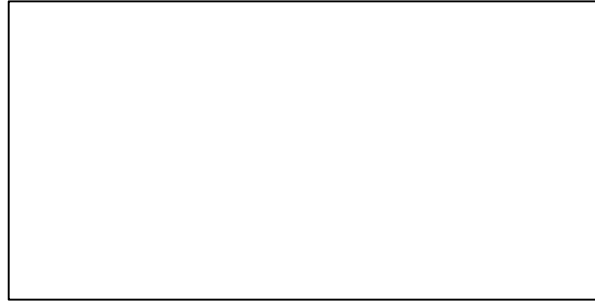
RA reminder: If the participant previously indicated that s/he has not taken medications specifically for HIV (ADE item #26 = NO) and/or has not been prescribed any anti-HIV medications (ADH item #1 = NO), staff should still administer the ADS form. However, the above instructions should refer to "next month" instead of "past month" and the lead in statement should be re-framed as, **"If you were to be prescribed HIV medications in the next month, how confident are you that you can:"**

RA reminder: If the participant previously indicated that s/he has not been prescribed any anti-HIV medications (ADH item #1 = NO), staff should still administer the ADS form. However, the above instructions should refer to "next month" instead of "past month" and the lead in statement should be re-framed as, **"If you were to be prescribed HIV medications in the next month, how confident are you that you can:"**

In the past month, how confident are you that you can:

[illegible]

Comments: (ADSCOMM)



NIDA Clinical Trials Network

ARVs Med Log (ARV)

Web Version: 1.0; 2.02; 09-05-13

You said you had been prescribed anti-HIV medications. Are you currently taking anti-HIV medication?

If "no," RA Instructions: You may need to remind the participant that s/he answered "Yes" to item number 1 on the Shortened HIV Adherence Measures form and ask for clarification on his/her response. Even if the participant has poor adherence, if s/he has an active prescription of antiretrovirals that s/he is currently taking even SOMETIMES, enter it on the ARV log.

If "yes," ask: "What are the names of your medications? Do you have your medications or a list with you? When did you start your current regimen?"

RA Instructions: If the participant does not have a list or medication bottles, you may need to help him/her remember the medications. Use the laminated card with pictures of the pills to help the participant identify his/her medication. Utilize the "Common Regimens" list to suggest names; use both generic and brand names to jog his/her memory. ONLY record antiretroviral medications on this log; other medications, even those for OI prevention, should NOT be added to the log.

	Drug Name	Start Date (mm/dd/yyyy)	Stop Date (mm/dd/yyyy)	Self-Report	Medical Record
1.	<div style="border: 1px solid black; height: 100px; width: 100%;"></div> <div style="background-color: #000080; height: 15px; width: 100%;"></div> <div style="font-size: small; margin-top: 5px;">(ARDRUG01)</div>	<div style="display: flex; align-items: center;"> (ARST01DT) <input style="width: 60px; border: 1px solid black;" type="text"/> Calendar </div>	<div style="display: flex; align-items: center;"> (ARSP01DT) <input style="width: 60px; border: 1px solid black;" type="text"/> Calendar </div>	<div style="display: flex; align-items: center;"> (ARSELF01) <input type="checkbox"/> </div>	<div style="display: flex; align-items: center;"> (ARMED01) <input type="checkbox"/> </div>
2.	<div style="border: 1px solid black; height: 100px; width: 100%;"></div> <div style="background-color: #000080; height: 15px; width: 100%;"></div> <div style="font-size: small; margin-top: 5px;">(ARDRUG02)</div>	<div style="display: flex; align-items: center;"> (ARST02DT) <input style="width: 60px; border: 1px solid black;" type="text"/> Calendar </div>	<div style="display: flex; align-items: center;"> (ARSP02DT) <input style="width: 60px; border: 1px solid black;" type="text"/> Calendar </div>	<div style="display: flex; align-items: center;"> (ARSELF02) <input type="checkbox"/> </div>	<div style="display: flex; align-items: center;"> (ARMED02) <input type="checkbox"/> </div>
3.	<div style="border: 1px solid black; height: 100px; width: 100%;"></div> <div style="background-color: #000080; height: 15px; width: 100%;"></div> <div style="font-size: small; margin-top: 5px;">(ARDRUG03)</div>	<div style="display: flex; align-items: center;"> (ARST03DT) <input style="width: 60px; border: 1px solid black;" type="text"/> Calendar </div>	<div style="display: flex; align-items: center;"> (ARSP03DT) <input style="width: 60px; border: 1px solid black;" type="text"/> Calendar </div>	<div style="display: flex; align-items: center;"> (ARSELF03) <input type="checkbox"/> </div>	<div style="display: flex; align-items: center;"> (ARMED03) <input type="checkbox"/> </div>
4.	<div style="border: 1px solid black; height: 100px; width: 100%;"></div> <div style="background-color: #000080; height: 15px; width: 100%;"></div> <div style="font-size: small; margin-top: 5px;">(ARDRUG04)</div>	<div style="display: flex; align-items: center;"> (ARST04DT) <input style="width: 60px; border: 1px solid black;" type="text"/> Calendar </div>	<div style="display: flex; align-items: center;"> (ARSP04DT) <input style="width: 60px; border: 1px solid black;" type="text"/> Calendar </div>	<div style="display: flex; align-items: center;"> (ARSELF04) <input type="checkbox"/> </div>	<div style="display: flex; align-items: center;"> (ARMED04) <input type="checkbox"/> </div>

5.	<div> <div></div> <div></div> </div> <div>(ARDRUG05)</div>	<div> <div></div> <div></div> </div> <div>(ARST05DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSP05DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSELF05) <input type="checkbox"/></div>	<div> <div></div> <div></div> </div> <div>(ARMED05) <input type="checkbox"/></div>
6.	<div> <div></div> <div></div> </div> <div>(ARDRUG06)</div>	<div> <div></div> <div></div> </div> <div>(ARST06DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSP06DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSELF06) <input type="checkbox"/></div>	<div> <div></div> <div></div> </div> <div>(ARMED06) <input type="checkbox"/></div>
7.	<div> <div></div> <div></div> </div> <div>(ARDRUG07)</div>	<div> <div></div> <div></div> </div> <div>(ARST07DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSP07DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSELF07) <input type="checkbox"/></div>	<div> <div></div> <div></div> </div> <div>(ARMED07) <input type="checkbox"/></div>
8.	<div> <div></div> <div></div> </div> <div>(ARDRUG08)</div>	<div> <div></div> <div></div> </div> <div>(ARST08DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSP08DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSELF08) <input type="checkbox"/></div>	<div> <div></div> <div></div> </div> <div>(ARMED08) <input type="checkbox"/></div>
9.	<div> <div></div> <div></div> </div> <div>(ARDRUG09)</div>	<div> <div></div> <div></div> </div> <div>(ARST09DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSP09DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSELF09) <input type="checkbox"/></div>	<div> <div></div> <div></div> </div> <div>(ARMED09) <input type="checkbox"/></div>
10.	<div> <div></div> <div></div> </div> <div>(ARDRUG10)</div>	<div> <div></div> <div></div> </div> <div>(ARST10DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSP10DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSELF10) <input type="checkbox"/></div>	<div> <div></div> <div></div> </div> <div>(ARMED10) <input type="checkbox"/></div>
11.	<div> <div></div> <div></div> </div> <div>(ARDRUG11)</div>	<div> <div></div> <div></div> </div> <div>(ARST11DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSP11DT) <input type="text"/> Calendar</div>	<div> <div></div> <div></div> </div> <div>(ARSELF11) <input type="checkbox"/></div>	<div> <div></div> <div></div> </div> <div>(ARMED11) <input type="checkbox"/></div>

12.	<div><div></div><div>(ARDRUG12)</div></div>	(ARST12DT) <input type="text"/> Calendar	(ARSP12DT) <input type="text"/> Calendar	(ARSELF12) <input type="checkbox"/>	(ARMED12) <input type="checkbox"/>
13.	<div><div></div><div>(ARDRUG13)</div></div>	(ARST13DT) <input type="text"/> Calendar	(ARSP13DT) <input type="text"/> Calendar	(ARSELF13) <input type="checkbox"/>	(ARMED13) <input type="checkbox"/>
14.	<div><div></div><div>(ARDRUG14)</div></div>	(ARST14DT) <input type="text"/> Calendar	(ARSP14DT) <input type="text"/> Calendar	(ARSELF14) <input type="checkbox"/>	(ARMED14) <input type="checkbox"/>
15.	<div><div></div><div>(ARDRUG15)</div></div>	(ARST15DT) <input type="text"/> Calendar	(ARSP15DT) <input type="text"/> Calendar	(ARSELF15) <input type="checkbox"/>	(ARMED15) <input type="checkbox"/>
16.	<div><div></div><div>(ARDRUG16)</div></div>	(ARST16DT) <input type="text"/> Calendar	(ARSP16DT) <input type="text"/> Calendar	(ARSELF16) <input type="checkbox"/>	(ARMED16) <input type="checkbox"/>
17.	<div><div></div><div>(ARDRUG17)</div></div>	(ARST17DT) <input type="text"/> Calendar	(ARSP17DT) <input type="text"/> Calendar	(ARSELF17) <input type="checkbox"/>	(ARMED17) <input type="checkbox"/>
18.	<div><div></div><div>(ARDRUG18)</div></div>	(ARST18DT) <input type="text"/> Calendar	(ARSP18DT) <input type="text"/> Calendar	(ARSELF18) <input type="checkbox"/>	(ARMED18) <input type="checkbox"/>

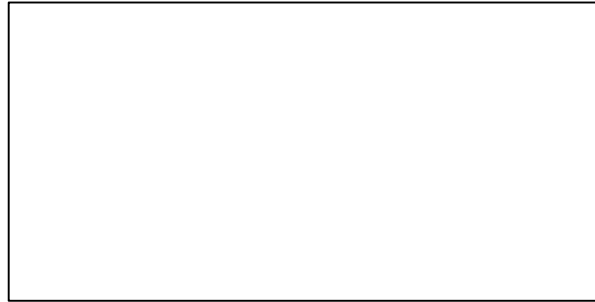
19.	<div><div></div><div>(ARDRUG19)</div></div>	(ARST19DT) <input type="text"/> Calendar	(ARSP19DT) <input type="text"/> Calendar	(ARSELF19) <input type="checkbox"/>	(ARMED19) <input type="checkbox"/>
20.	<div><div></div><div>(ARDRUG20)</div></div>	(ARST20DT) <input type="text"/> Calendar	(ARSP20DT) <input type="text"/> Calendar	(ARSELF20) <input type="checkbox"/>	(ARMED20) <input type="checkbox"/>
21.	<div><div></div><div>(ARDRUG21)</div></div>	(ARST21DT) <input type="text"/> Calendar	(ARSP21DT) <input type="text"/> Calendar	(ARSELF21) <input type="checkbox"/>	(ARMED21) <input type="checkbox"/>
22.	<div><div></div><div>(ARDRUG22)</div></div>	(ARST22DT) <input type="text"/> Calendar	(ARSP22DT) <input type="text"/> Calendar	(ARSELF22) <input type="checkbox"/>	(ARMED22) <input type="checkbox"/>
23.	<div><div></div><div>(ARDRUG23)</div></div>	(ARST23DT) <input type="text"/> Calendar	(ARSP23DT) <input type="text"/> Calendar	(ARSELF23) <input type="checkbox"/>	(ARMED23) <input type="checkbox"/>
24.	<div><div></div><div>(ARDRUG24)</div></div>	(ARST24DT) <input type="text"/> Calendar	(ARSP24DT) <input type="text"/> Calendar	(ARSELF24) <input type="checkbox"/>	(ARMED24) <input type="checkbox"/>
25.	<div><div></div><div>(ARDRUG25)</div></div>	(ARST25DT) <input type="text"/> Calendar	(ARSP25DT) <input type="text"/> Calendar	(ARSELF25) <input type="checkbox"/>	(ARMED25) <input type="checkbox"/>

26.	<div><div></div><div>(ARDRUG26)</div></div>	(ARST26DT) <input type="text"/> Calendar	(ARSP26DT) <input type="text"/> Calendar	(ARSELF26) <input type="checkbox"/>	(ARMED26) <input type="checkbox"/>
27.	<div><div></div><div>(ARDRUG27)</div></div>	(ARST27DT) <input type="text"/> Calendar	(ARSP27DT) <input type="text"/> Calendar	(ARSELF27) <input type="checkbox"/>	(ARMED27) <input type="checkbox"/>
28.	<div><div></div><div>(ARDRUG28)</div></div>	(ARST28DT) <input type="text"/> Calendar	(ARSP28DT) <input type="text"/> Calendar	(ARSELF28) <input type="checkbox"/>	(ARMED28) <input type="checkbox"/>
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30.	<div><div></div><div>(ARDRUG30)</div></div>	(ARST30DT) <input type="text"/> Calendar	(ARSP30DT) <input type="text"/> Calendar	(ARSELF30) <input type="checkbox"/>	(ARMED30) <input type="checkbox"/>
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33.	<div> <div></div> <div>(ARST33DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSP33DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSELF33) <input type="checkbox"/></div> </div> <div> <div></div> <div>(ARMED33) <input type="checkbox"/></div> </div>
34.	<div> <div></div> <div>(ARST34DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSP34DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSELF34) <input type="checkbox"/></div> </div> <div> <div></div> <div>(ARMED34) <input type="checkbox"/></div> </div>
35.	<div> <div></div> <div>(ARST35DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSP35DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSELF35) <input type="checkbox"/></div> </div> <div> <div></div> <div>(ARMED35) <input type="checkbox"/></div> </div>
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37.	<div> <div></div> <div>(ARST37DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSP37DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSELF37) <input type="checkbox"/></div> </div> <div> <div></div> <div>(ARMED37) <input type="checkbox"/></div> </div>
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39.	<div> <div></div> <div>(ARST39DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSP39DT) <input type="text"/> Calendar</div> </div> <div> <div></div> <div>(ARSELF39) <input type="checkbox"/></div> </div> <div> <div></div> <div>(ARMED39) <input type="checkbox"/></div> </div>

40.	<div><div></div><div>(ARDRUG40)</div></div>	(ARST40DT) <input type="text"/> Calendar	(ARSP40DT) <input type="text"/> Calendar	(ARSELF40) <input type="checkbox"/>	(ARMED40) <input type="checkbox"/>
41.	<div><div></div><div>(ARDRUG41)</div></div>	(ARST41DT) <input type="text"/> Calendar	(ARSP41DT) <input type="text"/> Calendar	(ARSELF41) <input type="checkbox"/>	(ARMED41) <input type="checkbox"/>
42.	<div><div></div><div>(ARDRUG42)</div></div>	(ARST42DT) <input type="text"/> Calendar	(ARSP42DT) <input type="text"/> Calendar	(ARSELF42) <input type="checkbox"/>	(ARMED42) <input type="checkbox"/>
43.	<div><div></div><div>(ARDRUG43)</div></div>	(ARST43DT) <input type="text"/> Calendar	(ARSP43DT) <input type="text"/> Calendar	(ARSELF43) <input type="checkbox"/>	(ARMED43) <input type="checkbox"/>
44.	<div><div></div><div>(ARDRUG44)</div></div>	(ARST44DT) <input type="text"/> Calendar	(ARSP44DT) <input type="text"/> Calendar	(ARSELF44) <input type="checkbox"/>	(ARMED44) <input type="checkbox"/>
45.	<div><div></div><div>(ARDRUG45)</div></div>	(ARST45DT) <input type="text"/> Calendar	(ARSP45DT) <input type="text"/> Calendar	(ARSELF45) <input type="checkbox"/>	(ARMED45) <input type="checkbox"/>

Comments: (ARVCOMM)



Additional Selection Options for ARV

Drug name 01

06 -Edurant - RPV
07 -Emtriva - FTC
08 -Epivir - 3TC
09 -Epzicom - ABC + 3TC
10 -Fuzeon - T20
11 -Intelence - ETV
12 -Invirase - SQV
13 -Isentress - RAL
34 -Isentress + Truvada - RAL + TDF + FTC
14 -Kaletra - LPV/r
15 -Lexiva - FPV
16 -Norvir - RTV
33 -Other/Experimental/Blinded study - OTHR
18 -Prezista BID - DRV
17 -Prezista QD - DRV
36 -Prezista + Norvir +Truvada (DRV/r twice daily) - DRV/r +TDF + FTC
35 -Prezista + Norvir + Truvada (once daily) - DRV/r + TDF + FTC
19 -Reyataz - ATV
37 -Reyataz + Norvir + Truvada
- ATV/r + TDF + FTC
20 -Rescriptor - DLV
21 -Retrovir - AZT (or ZDV)
22 -Selzentry - MVC
38 -Selzentry + Truvada - MVC + TDF + FTC
39 -Stribild - EVG + COBI + TDF + FTC
23 -Sustiva - EFV
40 -Tivacay (dolutegravir)
24 -Trizivir - ABC + 3TC + ZDV (or AZT)
25 -Truvada - TDF + FTC
26 -Videx - ddl
27 -Viracept - NFV
28 -Viramune - NVP
29 -Viramune XR (QD) - NVP
30 -Viread - TDF
31 -Zerit - d4T
32 -Ziagon - ABC

NIDA Clinical Trials Network

CTN-ASI Lite v. 1: Drug/Alcohol Use (ASA)

Web Version: 1.0; 2.00; 12-02-14

Segment (PROTSEG):

Visit Number (VISNO):

Date of assessment: (ASAASMDT)

(mm/dd/yyyy) [Click here for calendar](#)

CTN-ASI Lite v. 1: Drug/Alcohol Use

Route of Administration:

1 = Oral 2 = Nasal 3 = Smoking 4 = Non-IV injection 5 = IV injection

Note the **usual or most recent route**. For more than one route, choose the most severe.

The routes are listed from least severe to most severe. If Past 30 Days and Lifetime Use are zero, route should be "Not applicable".

Substance	B Lifetime Use (Years)	A Past 30 (Days)	C Age of First Use (onset)	C Age of First Use (onset) Not Applicable	D Route of Administration	Comments
D1 Alcohol (any use at all):	(ASALALFT) _____ (xx)	(ASALA30D) _____ (xx)	(ASALONST) _____ (xx)	Onset: (ASALONNA) <input type="checkbox"/> NA	-	(ASALACOM) _____
D2 Alcohol (to intoxication):	(ASALILFT) _____ (xx)	(ASALI30D) _____ (xx)	(ASALIONS) _____ (xx)	Onset: (ASALIONA) <input type="checkbox"/> NA	-	(ASALICOM) _____
D3 Heroin	(ASHERLFT) _____ (xx)	(ASHER30D) _____ (xx)	(ASHERONS) _____ (xx)	Onset: (ASHERONA) <input type="checkbox"/> NA	(ASHERRTE) <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	(ASHERCOM) _____
D4 Methadone/LAAM (prescribed):	(ASMDPLFT) _____ (xx)	(ASMDP30D) _____ (xx)	(ASMDPONS) _____ (xx)	Onset: (ASMDPONA) <input type="checkbox"/> NA	(ASMDPRTE) <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	(ASMDPCOM) _____
D4a Methadone/LAAM	(ASMLILFT) _____ (xx)	(ASMLI30D) _____ (xx)	(ASMLIONS) _____ (xx)	Onset:	(ASMLIRTE) _____	(ASMLICOM) _____

(illicit):	<div><div></div>(xx)</div>	<div><div></div>(xx)</div>	<div><div></div>(xx)</div>	(ASMLIONA) <input type="checkbox"/> NA	<div><div></div></div>	
D5 Other Opiates/Analgesics:	(ASOPIFLT) <div><div></div>(xx)</div>	(ASOPI30D) <div><div></div>(xx)</div>	(ASOPIONS) <div><div></div>(xx)</div>	Onset: (ASOPIONA) <input type="checkbox"/> NA	(ASOPIRTE) <div><div></div></div>	(ASOPICOM) <div><div></div></div>
D6 Barbiturates:	(ASBARFLT) <div><div></div>(xx)</div>	(ASBAR30D) <div><div></div>(xx)</div>	(ASBARONS) <div><div></div>(xx)</div>	Onset: (ASBARONA) <input type="checkbox"/> NA	(ASBARRTE) <div><div></div></div>	(ASBARCOM) <div><div></div></div>
D7 Other Sedatives/Hypnotics/Tranquilizers:	(ASSHTFLT) <div><div></div>(xx)</div>	(ASSHT30D) <div><div></div>(xx)</div>	(ASSHTONS) <div><div></div>(xx)</div>	Onset: (ASSHTONA) <input type="checkbox"/> NA	(ASSHTRTE) <div><div></div></div>	(ASSHTCOM) <div><div></div></div>
D8 Cocaine:	(ASCOCLFT) <div><div></div>(xx)</div>	(ASCOC30D) <div><div></div>(xx)</div>	(ASCOCONS) <div><div></div>(xx)</div>	Onset: (ASCOCONA) <input type="checkbox"/> NA	(ASCOCRTE) <div><div></div></div>	(ASCOCOM) <div><div></div></div>
D9 Amphetamines:	(ASAMPLFT) <div><div></div>(xx)</div>	(ASAMP30D) <div><div></div>(xx)</div>	(ASAMPONS) <div><div></div>(xx)</div>	Onset: (ASAMPONA) <input type="checkbox"/> NA	(ASAMP RTE) <div><div></div></div>	(ASAMP COM) <div><div></div></div>

					1-(1) Oral 2-(2) Nasal 3-(3) Smoking 4-(4) Non IV injection 5-(5) IV injection 96-(96) Not applicable 97-(97) Not answered	
D10 Cannabis:	(ASTHCLFT) <input type="text"/> (xx)	(ASTHC30D) <input type="text"/> (xx)	(ASTHCONS) <input type="text"/> (xx)	Onset: (ASTHCONA) <input type="checkbox"/> NA	(ASTHCRTE) <input type="text"/>	(ASTHCCOM) <input type="text"/>
D11 Hallucinogens:	(ASHALLFT) <input type="text"/> (xx)	(ASHAL30D) <input type="text"/> (xx)	(ASHALONS) <input type="text"/> (xx)	Onset: (ASHALONA) <input type="checkbox"/> NA	(ASHALRTE) <input type="text"/>	(ASHALCOM) <input type="text"/>
D12 Inhalants:	(ASINHLFT) <input type="text"/> (xx)	(ASINH30D) <input type="text"/> (xx)	(ASINHONS) <input type="text"/> (xx)	Onset: (ASINHONA) <input type="checkbox"/> NA	(ASINHRTE) <input type="text"/>	(ASINHCOM) <input type="text"/>
D13 More than 1 substance per day (including alcohol, excluding nicotine):	(ASGT1LFT) <input type="text"/> (xx)	(ASGT130D) <input type="text"/> (xx)	(ASGT1ONS) <input type="text"/> (xx)	Onset: (ASGT1ONA) <input type="checkbox"/> NA	-	(ASGT1COM) <input type="text"/>

D14 Currently, which substance is the major problem?

- Interviewer should determine the major drug or drugs of abuse (excluding Nicotine use). Code the number next to the drug in 01-12 (code prescribed or illicit methadone as 04). 00 = no problem, 15 = alcohol and one or more drugs; 16 = more than one drug but no alcohol. Ask participant when not clear.

0-00 - No problem
1-01 - Alcohol (any use at all)
2-02 - Alcohol (to intoxication)
3-03 - Heroin
4-04 - Methadone/LAAM (prescribed or illicit)
5-05 - Other Opiates/Analgesics
6-06 - Barbiturates
7-07 - Other Sedatives/Hypnotics/Tranquilizers
8-08 - Cocaine
9-09 - Amphetamines
9a-09a - Methamphetamine
10-10 - Cannabis
11-11 - Hallucinogens
12-12 - Inhalants
15-15 - Alcohol & one or more drugs
16-16 - More than one drug, but no alcohol

(ASMAJDRG)

OR

(ASMJDGNA) ☐ (97) Not Answered

Comments: (ASMJDGCM)

D17 How many times have you had Alcohol DT's?

- Delirium Tremens (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake. Characterized by shaking, severe disorientation, fever, hallucinations; they usually require medical attention.

(ASALCDT) (xxx)

OR

(ASALDTNA) ☐ (97) Not Answered

Comments: (ASALDTCM)

How many times in your life have you been treated for:

Include detoxification, halfway houses, in/outpatient counseling and AA or NA (if 3+ meetings within one month period).

D19 Alcohol abuse:

(ASALCTRT) (xx)

OR

(ASATRTNA) ☐ (97) Not Answered

Comments: (ASATRTCM)

D20 Drug abuse:

(ASDRGTRT) (xx)

OR

(ASDTRTNA) ☐ (97) Not Answered

Comments: (ASDTRTCM)

How many of these were detox only:

D21 Alcohol:

- If D19 = 00, then question D21 is Not applicable.

(ASADETOX) (xx)

OR

(ASADTXNA) ☐ (96) Not applicable ☐ (97) Not answered

Comments: (ASADTXCM)

D22 Drugs:

- If D20 = 00, then question D22 is Not applicable.

(ASDDETOX) (xx)

OR

(ASDDTXNA) ☐ (96) Not applicable ☐ (97) Not answered

Comments: (ASDDTXCM)

How much money would you say you spent during the past 30 days on:

Max. = \$99999

D23 Alcohol:

- Only count actual money spent. What is the financial burden caused by alcohol?

(ASALCMNY) \$ (xxxxx)

OR

(ASAMNYNA) ☐ (97) Not Answered

Comments: (ASAMNYCM)

D24 Drugs:

- *Only count actual money spent. What is the financial burden caused by drugs?*

(ASDRGMNY) \$ (xxxxx)

OR

(ASDMNYNA) ☐ (97) Not Answered

Comments: (ASDMNYCM)

D25 How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days?

- *Include AANA*

(ASOUTPAT) (xx) days

OR

(ASOPTNA) ☐ (97) Not Answered

Comments: (ASOPTCOM)

D26 How many days in the past 30 have you experienced alcohol problems?

- *Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.*

(ASAP30D) (xx) days

OR

(ASAP30NA) ☐ (97) Not Answered

Comments: (ASAP30CM)

For questions D28-D31, please ask participant to use the Participant Rating Scale. The participant is rating the need for additional substance abuse treatment.

D28 How troubled or bothered have you been in the past 30 days by these alcohol problems?

(ASAPB30D)

OR

(ASAB30NA) ☐ (97) Not Answered

Comments: (ASAB30CM)

D30 How important to you **now** is treatment for these alcohol problems?

(ASAPI30D)

OR

(ASA30NA) ☐ (97) Not Answered

Comments: (ASA30CM)

D27 How many days in the past 30 have you experienced drug problems?

- *Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.*

(ASDP30D) (xx) days

OR

(ASDP30NA) ☐ (97) Not Answered

Comments: (ASDP30CM)

D29 How troubled or bothered have you been in the past 30 days by these drug problems?

(ASDPB30D)

OR

(ASDB30NA) ☐ (97) Not Answered

Comments: (ASDB30CM)

D31 How important to you **now** is treatment for these drug problems?

(ASDPI30D)

OR

(ASDI30NA) ☐ (97) Not Answered

Comments: (ASDI30CM)

Confidence Ratings: Is the above information **significantly** distorted by:

D34 Participant's misrepresentation?

(ASMISREP) ☐ (0) No ☐ (1) Yes

D35 Participant's inability to understand?

(ASUNDRST) ☐ (0) No ☐ (1) Yes

Comments: (ASACOMM)

List of Commonly Used Drugs

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Diluaidid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2, 3, 4 Syrups = Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax, Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate (Noctex), Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine or "Crack", and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy
Inhalants:	Nitrous Oxide, Amyl Nitrate (Whippits, Poppers), Glue, Solvents, Gasoline, Toluene, etc.

Just note if these are used: Antidepressants,
Ulcer Meds = Zantac, Tagamet
Asthma Meds = Ventoline Inhaler, Theodur
Other meds = Antipsychotics, Lithium

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Access to Care Scale (ATC)

Web Version: 1.0; 1.00; 07-06-12

Segment (PROTSEG):

Visit Number (VISNO):

Now I'm going to read you some statements about health care that ask about the past 6 months.

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

Date of assessment: (ATCASMDT)

(mm/dd/yyyy) [Click here for calendar](#)

I am going to read you some statements that ask about the past 6 months.

Tell me if you strongly agree, somewhat agree, are uncertain, somewhat disagree, or strongly disagree with each statement.

In the past 6 months, would you say:	Strongly agree	Somewhat agree	Uncertain	Somewhat disagree	Strongly disagree
1. If I need hospital care, I can get admitted without trouble.	(ATADMIT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. It is hard for me to get medical care in an emergency.	(ATERCARE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sometimes I go without the medical care I need because it is too expensive.	(ATEXPNSV) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have easy access to the medical specialists that I need.	(ATACCESS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Places where I can get medical care are very conveniently located.	(ATLOCATN) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I am able to get medical care whenever I need it.	(ATMDCARE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: (ATCCOMM)

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AUDIT (AUC)

Web Version: 1.0; 4.01; 10-21-13

Segment (*PROTSEG*):

Visit Number (*VISNO*):

The next several questions are about alcohol use over the past 1 year.

The next several questions are about alcohol use since your last visit.

RA Instruction: Provide participant with a reference card that lists all 5 response options for his/her easy reference.

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

Date of assessment: (*AUCASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

1. How often do you have a drink containing alcohol? (*AUALFREQ*)

0-Never
1-Monthly or less
2-2 to 4 times a month
3-2 to 3 times a week
4-4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when drinking? (*AUNUMBER*)

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more drinks on one occasion?	(<i>AU6DRINK</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often during the last year have you found that you were unable to stop drinking once you started?	(<i>AUNOSTP</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	(<i>AUEXPECT</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	(<i>AUAMDRNK</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often during the last year have you felt guilt or remorse after drinking?	(<i>AUGUILTY</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often during the last year have you been unable to remember what happened the night before because of drinking?	(<i>AUREMBR</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Does the hospital system medical record has evidence of heavy alcohol use in the past 12 months?
(AUHYYALC)

a. If "Yes", specify source of evidence:

Clinician notes:(AUCLINSO)

Toxicology report for alcohol:(AUTOXSO)

b. If source is "Toxicology report", specify alcohol level:(AUALCLVL)

c. If source is "Toxicology report", date toxicology for alcohol obtained:(AUTOXDT)

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

(x.xx) %

(mm/dd/yyyy) [Click here for calendar](#)

10. Have you or someone else been injured as a result of your drinking?(AUINJURD)

0-No

2-Yes, but not in the last year

4-Yes, during the last year

12. Has a relative, friend, doctor, or other health worker, been concerned about your drinking or suggested you cut down?(AUCONCRN)

Total score (include screening numbers):(AUSCORE)

(xx)

Total score:(AUSCORE)

(xx)

Comments:(AUCCOMM)

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Web Version: 1.0; 2.01; 06-20-13

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Visit Number (VISNO):

The next set of questions consist of a list of problems that people sometimes have. I will read each problem to you. Then you can tell me the number of the response that best describes how much that problem has distressed or bothered you during the past 7 days, including today.

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

Body aches (BSEXAMPL) ☐ 0 = Not at all ☐ 1 = A little bit ☐ 2 = Moderately ☐ 3 = Quite a bit ☐ 4 = Extremely

Body aches(*BSEXAMPL*) ☐ 0 = Not at all ☐ 1 = A little bit ☐ 2 = Moderately ☐ 3 = Quite a bit ☐ 4 = Extremely

How much were you distressed by:	NOT AT ALL 0	A LITTLE BIT 1	MODERATELY 2	QUITE A BIT 3	EXTREMELY 4
1. Faintness or dizziness:	(BSFNTDIZ) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling no interest in things:	(BSNOINT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Nervousness or shakiness inside:	(BSNERVOS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Pains in heart or chest:	(BSPAINHR) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feeling lonely:	(BSLONELY) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling tense or keyed up:	(BSTENSE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Nausea or upset stomach:	(BSNAUSE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Feeling blue:	(BSBLUE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Suddenly scared for no reason:	(BSSCARED) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Trouble getting your breath:	(BSBREATH) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feelings of worthlessness:	(BSWORTH) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Spells of terror or panic:	(BSTERRO) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Numbness or tingling in parts of body:	(BSNUMB) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Feeling hopeless about the future:	(BSHOPELS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Feeling so restless you couldn't sit still:	(BSRESTLS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Feeling weak in parts of your body:	(BSWEAK) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much were you distressed by:	NOT AT ALL 0	A LITTLE BIT 1	MODERATELY 2	QUITE A BIT 3	EXTREMELY 4
1. Faintness or dizziness:	(BSFNTDIZ) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling no interest in things:	(BSNOINT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Nervousness or shakiness inside:	(BSNERVOS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Pains in heart or chest:	(BSPAINHR) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feeling lonely:	(BSLONELY) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling tense or keyed up:	(BSTENSE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Nausea or upset stomach:	(BSNAUSE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Feeling blue:	(BSBLUE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Suddenly scared for no reason:	(BSSCARED) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Trouble getting your breath:	(BSBREATH) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feelings of worthlessness:	(BSWORTH) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Spells of terror or panic:	(BSTERRO) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Numbness or tingling in parts of body:	(BSNUMB) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Feeling hopeless about the future:	(BSHOPELS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Feeling so restless you couldn't sit still:	(BSRESTLS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Feeling weak in parts of your body:	(BSWEAK) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Thoughts of ending your life:	(BSENDLIF) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Feeling fearful:	(BSFEARFL) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Comments: (BSICOMM)

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Computer Assisted Personal Interview (CAP)

Web Version: 1.0; 1.00; 03-15-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Where is this assessment being performed? (*CAPLOCTN*)

Do not read these five lines of text to the participant.

Welcome!

You will be administering some questions using this computer by clicking on checkboxes like this: (*CAPBOX1*) ☐

When you're done, click on the "Save" button at the top or bottom of the screen.

Try it out!

Click this checkbox and then click on the "Save" button: (*CAPBOX2*) ☐

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Concise Health Risk Tracking (CHRT) Participant Rated Module (CHR)

Web Version: 1.0; 3.00; 06-27-13

Segment (*PROTSEG*):

Visit Number (*VISNO*):

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

Date of assessment: (*CHASMTDT*)

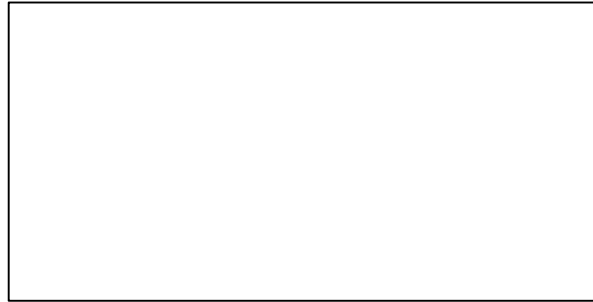
(mm/dd/yyyy) [Click here for calendar](#)

Please rate the extent to which each of the following statements describes how you have been feeling or acting in the past week.

For example, if you feel the statement very accurately describes how you have been feeling in the past week, you would give a rating of "Strongly Agree." If you feel the statement is not at all how you have been feeling in the past week, you would give a rating of "Strongly Disagree."

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I feel as if things are never going to get better.	(CHNVRBTR) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I have no future.	(CHNOFUTR) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. It seems as if I can do nothing right.	(CHNOTHRT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Everything I do turns out wrong.	(CHWRONG) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. There is no one I can depend on.	(CHDPNDON) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The people I care the most for are gone.	(CHPPLGNE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I wish my suffering could just all be over.	(CHSUFOVR) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I feel that there is no reason to live.	(CHRSLIVE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I wish I could just go to sleep and not wake up.	(CHSLPNTW) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I find myself saying or doing things without thinking.	(CHNOTHINK) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I often make decisions quickly or "on impulse."	(CHIMPULS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I often feel irritable or easily angered.	(CHIRRITE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I often overreact with anger or rage over minor things.	(CHOVRRCT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I have been having thoughts of killing myself.	(CHKILLMS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I have thoughts about how I might kill myself.	(CHHOWKIL) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I have a plan to kill myself.	(CHPLNKIL) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: (CHRCOMM)



NIDA Clinical Trials Network

Clinical Labs Data (CLD)

Web Version: 1.0; 9.05; 01-27-14

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Study Labs

1. Participant has a detectable (>200 copies/mL) viral load or unknown level in the past 12 months: (*CDVRL OAD*)

a. If "Yes" or "No", specify viral load: (*CDLOADVL*)

b. Date viral load obtained: (*CDLOADDT*)

☐ No ☐ Yes

(xxxxxxx) copies per mL - OR - (*CDVRUNK*) ☐ Unknown

(mm/dd/yyyy) [Click here for calendar](#)

2. Participant's most recent CD4 count <=500 cells/uL in the past 12 months: (*CDBSECD4*)

a. If "Yes" or "No", specify CD4 count: (*CDCD4VAL*)

b. Date CD4 count obtained: (*CDCD4DT*)

☐ No ☐ Yes ☐ Unknown

(xxxxx) cells/μL

(mm/dd/yyyy) [Click here for calendar](#)

3. It is the Site PI's discretion that the participant is likely to currently have a viral load greater than 200 copies/mL, is not currently successfully/correctly taking ART, and needs to be on ART: (*CDPI*)

☐ No ☐ Yes

4. Has the participant had an AIDS defining illness during the current hospital admission? (*CDAIDS*)

If "Yes", specify: (*CDAIDSSP*)

☐ No ☐ Yes

5. Was a sample collected? (*CDCOLTD*)

If "Yes," date: (*CDCOLTDT*)

☐ No ☐ Yes

(mm/dd/yyyy) [Click here for calendar](#)

6. CD4 collection method: (*CDCD4CLT*)

a. CD4 collection date: (*CDCD4CDT*)

b. CD4: (*CDCD4C*)

c. CD4 %: (*CDCD4P*)

(mm/dd/yyyy) [Click here for calendar](#)

(xxxxx) (cells/μL)

(xxx.x) %

7. Viral load collection method: (*CDVLCLT*)

a. Viral load collection date: (*CDVLCDT*)

b. Is HIV viral load undetectable? (*CDHIVVLU*)

(mm/dd/yyyy) [Click here for calendar](#)

☐ No ☐ Yes

- c. If "Yes," what is your lab's lower limit? (CDLOWER)
- d. If "No," how many copies? (CDCOPIES)
- e. VL Assay Type: (CDASSAY)
8. CBC collection method: (CDCBCCLT)

< (xxx) (copies/mL)

(xxxxxxx) (copies/mL)

(mm/dd/yyyy) [Click here for calendar](#)

(xx.x) g/dL

(xx.x) %

(xxx.x) k/ μ L

(xxxx) k/ μ L

- a. CBC collection date: (CDCBCCDT)
- b. Hemoglobin: (CDHGB)
- c. Hematocrit: (CDHCT)
- d. WBC: (CDWBC)
- e. Platelets: (CDPLAT)

BMI

9. Height: (CDHGHTIN)
10. Weight: (CDWGHTLB)
- Was weight measured or abstracted? (CDWGHTMA)
11. BMI: (CDCALC)

(xx) in - OR - (CDHGHTCM) (xxx) cm

(xxx.x) lbs - OR - (CDWGHTKG) (xxx.x) kg

☐ Measured ☐ Abstracted

Abstracted Labs

Lab values within the 6 months prior to Date of Randomization through 1 month after Date of Randomization

Lab Name	Date Collected	Date Collected	Value	Alternate Value
12. Creatinine:	(CDCREDT) <input type="text"/> Calendar	(CDCREDT) <input type="text"/> Calendar	(CDCREAT) <input type="text"/> (xx.xx) mg/dL	
13. eGFR calculated by lab:	(CDEGFRDT) <input type="text"/> Calendar	(CDEGFRDT) <input type="text"/> Calendar	(CDEGFR) <input type="text"/> (xxx.x) mL/min/1.73 m ²	(CDEGFRNE) - OR - > <input type="text"/> (xxx) mL/min/1.73 m ²
14. Total bilirubin:	(CDTBILDT) <input type="text"/> Calendar	(CDTBILDT) <input type="text"/> Calendar	(CDTBILI) <input type="text"/> (xx.xx) mg/dL	
15. Direct bilirubin:	(CDDBILDT) <input type="text"/> Calendar	(CDDBILDT) <input type="text"/> Calendar	(CDDBILI) <input type="text"/> (xx.xx) mg/dL	
16. Total protein:	(CDTPRODT) <input type="text"/> Calendar	(CDTPRODT) <input type="text"/> Calendar	(CDTPROT) <input type="text"/> (xx.x) g/dL	
17. Albumin:	(CDALBDT) <input type="text"/> Calendar	(CDALBDT) <input type="text"/> Calendar	(CDALB) <input type="text"/> (xx.x) g/dL	
18. AST:	(CDASTDT) <input type="text"/> Calendar	(CDASTDT) <input type="text"/> Calendar	(CDAST) <input type="text"/> (xxxxx) U/L	
19. ALT:	(CDALTDT) <input type="text"/> Calendar	(CDALTDT) <input type="text"/> Calendar	(CDALT) <input type="text"/> (xxxxx) U/L	
20. ALK phos:	(CDALKDT) <input type="text"/> Calendar	(CDALKDT) <input type="text"/> Calendar	(CDALK) <input type="text"/> (xxxxx) U/L	

-OR- no abstracted labs available: (CDNOABST)

☐

21. HCV antibody: (CDHCVAB)

HCV antibody collection date: (CDHCVDT)

Is the HCV viral load undetectable? (CDHCVVLU)

☐ Negative ☐ Positive

(mm/dd/yyyy) [Click here for calendar](#)

☐ No ☐ Yes ☐ Unknown

HCV viral load collection date:(CDHCVLDT)

(mm/dd/yyyy) [Click here for calendar](#)

If "No", how many copies?(CDHCVVL)

(xxxxxxx) (copies/mL)

22. Does the patient have a diagnosis of an AIDS defining illness listed in the past medical history or problem list?(CDDIAG)

☐ No ☐ Yes

AIDS defining illnesses include: candidiasis (bronchi, trachea, lungs, esophageal); coccidiomycosis (disseminated/extrapulmonary, cryptococcosis (extrapulmonary); cryptosporidiosis (>1 month), CMV (other than liver/spleen /lymphnodes), HIV encephalopathy; Herpes simplex (lung/esophageal or chronic ulcers>1 mo); histoplasmosis (disseminated/extrapulmonary), Kaposi's sarcoma; burkitt's lymphoma; immunoblastic lymphoma; primary CNS lymphoma; Mycobacterium avium complex or Mycobacterium kansasii; Other mycobacterium (disseminated, extrapulm); M. Tuberculosis (any site); pneumocystis jirovecii pneumonia; isosporiasis; progressive multifocal leukoencephalopathy; recurrent salmonella septicemia; toxoplasmosis of the brain; wasting syndrome due to HIV; invasive cervical cancer; recurrent pneumonia)

Ancillary Labs

Lab values within the ~~48~~-hours post Initial Hospital Admission Date

Lab Name	Date Collected	Value
23. PaO ₂ :	(CDPAO2DT) <input type="text"/> Calendar	(CDPAO2) <input type="text"/> (xxx) mmHg
24. Sodium (Na):	(CDSODIDT) <input type="text"/> Calendar	(CDSODIUM) <input type="text"/> (xxx) mEq/L
25. Chloride (Cl):	(CDCHLDT) <input type="text"/> Calendar	(CDCHLOR) <input type="text"/> (xxx) mmol/L
26. Bicarbonate (CO ₂):	(CDBICADT) <input type="text"/> Calendar	(CDBICARB) <input type="text"/> (xx) mmol

-OR- no ancillary labs available:(CDNOANCL)

☐

27. Absolute lymphocyte count:(CDALYMPH)

(xx.xx) x 10⁹/L Date collected:(CDALYMDT) (mm/dd/yyyy) [Calendar](#)

- OR -

28. WBC:(CDWBCAN)

(xx.xx) x 10⁹/L Date collected:(CDWBCADT) (mm/dd/yyyy) [Calendar](#)

29. Percentage lymphocytes:(CDLYMPCT)

(xxx) % Date collected:(CDLYMPDT) (mm/dd/yyyy) [Calendar](#)

Comments:(CLDCOMM)

Additional Selection Options for CLD

If "Yes", specify:

6-Burkitt's lymphoma

7-Immunoblastic lymphoma

8-Primary CNS lymphoma

9-Mycobacterium avium complex or Mycobacterium kansasii

10-Other mycobacterium (disseminated, extrapulm)

11-M. Tuberculosis (any site)

12-Pneumocystis jirovecii pneumonia

13-Isosporiasis

14-Progressive multifocal leukoencephalopathy

15-Recurrent salmonella septicemia

16-Toxoplasmosis of the brain

17-Wasting syndrome due to HIV

18-Invasive cervical cancer

19-Recurrent pneumonia

NIDA Clinical Trials Network

Cognitive Screening (COG)

Web Version: 1.0; 1.00; 03-09-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Date of assessment: (*COASMTDT*)

(mm/dd/yyyy) [Click here for calendar](#)

Memory-Registration - Give four words to recall (dog, hat, bean, red) - 1 second to say each. Then ask the patient all four words after you have said them. Repeat words if the patient does not recall them all immediately. Tell the patient you will ask for recall of the words again a bit later.

1. Motor Speed: Have the patient tap the thumb and forefinger of the non-dominant hand as widely and as quickly as possible. (*COMOTSPD*)

2. Psychomotor Speed: Have the patient perform the following movements with the non-dominant hand as quickly as possible:

- 1) Clench hand in fist on flat surface.
- 2) Put hand flat on surface with palm down.
- 3) Put hand perpendicular to flat surface on the side of the 5th digit.

Demonstrate and have patient perform twice for practice. (*COPSYSPD*)

Memory-Recall - Ask the patient to recall the four words. For words not recalled, prompt with a semantic clue as follows: animal (dog); piece of clothing (hat); vegetable (bean); color (red).

1. Recall: dog (*COMEDOG*)

2. Recall: hat (*COMEHAT*)

3. Recall: bean (*COMEBEAN*)

4. Recall: red (*COMERED*)

Comments: (COGCOMM)



Demographics (DEM)

Web Version: 1.0; 1.00; 06-03-11

1. Date of birth:(DEBRTHDT)

(mm/dd/yyyy)

2. Sex:(DEGENDER)

☐ Male

☐ Female

☐ Participant chooses not to answer

3. Ethnicity:(DEETHNIC)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Participant chooses not to answer

4. Race:

American Indian or Alaska Native(DEAMEIND)

Asian(DEASIAN)

Black or African American(DEBLACK)

Native Hawaiian or Pacific Islander(DEHAWAII)

White(DEWHITE)

Other(DEOTHER)

If "Yes", specify:(DEOTHRSP)

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

OR

Unknown(DEUNKNOWN)

Participant chooses not to provide their race(DENORACE)

☐ Yes

☐ Yes

Comments:(DEMCOMM)

NIDA Clinical Trials Network

DAST-10 (DST)

Web Version: 1.0; 1.00; 07-06-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

The next several questions are about drug use. Please answer No or Yes.

Date of assessment: (*DSTASMDT*)

(mm/dd/yyyy) [Click here to view calendar](#)

1. Have you used drugs other than those required for medical reasons? (*DSREASON*)
☐ No ☐ Yes
2. Do you use more than one drug at a time? (*DSABUSEM*)
☐ No ☐ Yes
3. Are you always able to stop using drugs when you want to? (*DSABLES*)
☐ No ☐ Yes
4. Have you had "blackouts" or "flashbacks" as a result of drug use? (*DSBLACK*)
☐ No ☐ Yes
5. Do you ever feel bad or guilty about your drug use? (*DSFEELB*)
☐ No ☐ Yes
6. Does your spouse/partner (or parents) ever complain about your involvement with drugs? (*DSSPOUSE*)
☐ No ☐ Yes
7. Have you neglected your family because of your use of drugs? (*DSNEGLEC*)
☐ No ☐ Yes
8. Have you engaged in illegal activities in order to obtain drugs? (*DSILLEGA*)
☐ No ☐ Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
(*DSWITHDR*)
☐ No ☐ Yes
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? (*DSPROBLE*)
☐ No ☐ Yes

Comments: (*DSTCOMM*)

Death Form (DTH)

Date of death (DTDTHDT):

- 1. Time of death (24-hour format):(DTDTHTM)
- 2. Date staff notified of death:(DTNOFYDT)
- 3. Date of last contact with participant:(DTCNTCDT)
- 4. Date of participant's last primary care visit:(DTPRIMDT)
- 5. Primary cause of death:(DTCAUSE)

(hh:mm)

(mm/dd/yyyy) [Click here for calendar](#)

(mm/dd/yyyy) [Click here for calendar](#)

(mm/dd/yyyy) [Click here for calendar](#)

If "Other", specify:(DTOTHER)

- 6. Secondary cause of death:(DT2COD)

If "Other", specify:(DT2CODSP)

7. Source:(DTSOURCE)

If "Other", specify:(DTSRCESP)

8. Was an autopsy performed?(DTAUTPSY)

Can a copy of the autopsy report be obtained?(DTAUTCPY)

☐ No ☐ Yes ☐ Unknown

☐ No ☐ Yes ☐ Unknown

9. Did death occur while the participant was hospitalized?(DTHOSP TZ)

If "No", where did the death occur?(DTPLACE)

☐ No ☐ Yes ☐ Unknown

10. Was participant seen in the emergency department within one week prior to death?(DTEDEVIST)

If "Yes", date of ED visit:(DTEDDT)

☐ No ☐ Yes ☐ Unknown

(mm/dd/yyyy) [Click here for calendar](#)

11. Was participant hospitalized within one week prior to death?(DTHSVIST)

If "Yes", admit date:(DTHSDT)

☐ No ☐ Yes ☐ Unknown

(mm/dd/yyyy) [Click here for calendar](#)

12. Was the participant discharged prior to death?(DTDISCHG)

If "Yes", discharge date:(DSDSCHDT)

☐ No ☐ Yes ☐ Unknown

(mm/dd/yyyy) [Click here for calendar](#)

13. Was drug use a contributing factor in the death?(DTDRUG)

☐ No ☐ Yes ☐ Unknown

14. Was alcohol a contributing factor in the death?(DTALCOHL)

☐ No ☐ Yes ☐ Unknown

15. Short narrative about the circumstance surrounding the death of the participant:(DTNARRTV)

Comments:(DTHCOMM)

If available, upload the autopsy, death report, discharge note, or any other supporting documentation.

Additional Selection Options for DTH

Primary cause of death:

- 6-Not obtainable
- 97-Unknown
- 99-Other

Secondary cause of death:

- 6-Malignancy (excluding skin cancer)
- 7-Diabetes
- 99-Other

NIDA Clinical Trials Network

0049A (ENR)

Web Version: 1.0; 1.01; 02-12-13

Date of assessment: (S6A SMDT)

(mm/dd/yyyy) [Click here for calendar](#)

Date informed consent signed for screening: (S6CNS TDT)

(mm/dd/yyyy) [Click here for calendar](#)

Pre-Screening ID (S6SCRNID)

(xxxx)

Comments: (S6COMM)

NIDA Clinical Trials Network

Fagerstrom Test for Nicotine Dependence (FTA)

Web Version: 1.0; 1.00; 07-06-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

The next few questions are about smoking habits.

Date of assessment (*FAASM TDT*)

(mm/dd/yyyy) [Click here for calendar](#)

Do you currently smoke cigarettes? (*FASMOKE*)

☐ No ☐ Yes

Please read each question below. For each question enter the answer choice which best describes your responses.

1. How soon after you wake up do you smoke your first cigarette? (*FAFSTCIG*)

2. Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in church, at the library, in cinema, etc.? (*FAFORBID*)

3. Which cigarette would you hate most to give up? (*FAGIVEUP*)

4. How many cigarettes/day do you smoke? (*FAPERDAY*)

5. Do you smoke more frequently during the first hours after waking than during the rest of the day? (*FAFREQ*)

6. Do you smoke if you are so ill that you are in bed most of the day? (*FAILL*)

Comments: (FTACOMM)



Heatherton TF; Kozlowski LT; Frecker RC; The Fagerström Test for Nicotine Dependence: a revision of the Fagerström Tolerance Questionnaire. *Br J Addict* (1991), 86, 119-1127.

NIDA Clinical Trials Network

Global Assessment of Functioning - Karnofsky (GAF)

Web Version: 1.0; 1.01; 06-20-13

Segment (PROTSEG):

Visit Number (VISNO):

Now I'm going to ask you a few questions about your functional status (your ability to care for yourself and perform activities on your own). Please think about your status immediately BEFORE you were admitted to this hospital.

Now I'm going to ask you a few questions about your functional status (your ability to care for yourself and perform activities on your own). Please think about your status in the past week.

Date of assessment: (GAFASMDT)

(mm/dd/yyyy) [Click here for calendar](#)

How would you rate this participant on the Karnofsky Performance Scale Index? The scale is below.

(GARA TING)

(xxx) %

Karnofsky Performance Status Scale

	Condition	Performance Status %	Comments
A.	Able to carry on normal activity and to work. No special care is needed.	100	Normal. No complaints. No evidence of disease.
		90	Able to carry on normal activity. Minor signs of symptoms or disease.
		80	Normal activity with effort. Some signs or symptoms of disease.
B.	Unable to work. Able to live at home, care for most personal needs. A varying degree of assistance is needed.	70	Cares for self. Unable to carry on normal activity or to do active work.
		60	Requires occasional assistance, but is able to care for most of his needs.
		50	Requires considerable assistance and frequent medical care.
C.	Unable to care for self. Requires equivalent of institutional or hospital care. Disease may be progressing rapidly.	40	Disabled. Requires special care and assistance.
		30	Severely disabled. Hospitalization is indicated although death not imminent.
		20	Hospitalization necessary, very sick active supportive treatment necessary.
		10	Moribund. Fatal processes progressing rapidly.
		0	Dead.

Comments: (GAFCOMM)

NIDA Clinical Trials Network

Gain Risk Behaviors - Modified (GRB)

Web Version: 1.0; 1.00; 10-25-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Date of assessment: (*GRBASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

We would like to ask a few personal questions about behaviors that may have affected your risk of getting or spreading infectious diseases. Remember that all of your answers are strictly confidential. The first questions are about the use of a needle to inject you with drugs or medication. Do **not** include shots given by a doctor or nurse, but **do** include if you were injected by someone besides a doctor or nurse **or** if you injected prescribed medication.

1. When was the **last** time, if ever, that you used a **needle to inject drugs or medication**?

Include medication prescribed by a doctor. (*GRLSTNDL*)

2. During the past 12 months, did you...

- a. Use a needle to shoot up drugs? (*GRNDSTUP*)
- b. Reuse a needle that **you** had used before? (*GRNDREUS*)
- c. Reuse a needle **without** cleaning it with bleach or boiling water first? (*GRNDNOCL*)
- d. Use a needle that you knew or suspected **someone else** had used before? (*GRNDELSE*)
- e. Use someone else's **rinse water, cooker, or cotton** after they did? (*GRNDH20*)
- f. Ever **skip** cleaning your needle with bleach or boiling water **after** you were done? (*GRNDSKIP*)
- g. Let someone else use a needle **after** you used it? (*GRNDAFTR*)
- h. Let someone else use the **rinse water, cooker, or cotton** after you did? (*GRNDH20A*)
- i. Allow someone else to inject you with drugs? (*GRNDINJT*)

- | | |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |

3. During the past 90 days:

- a. On how many **days** did you use a needle to inject any kind of drug or medication? (*GR90DUN*)
- b. With how many **people** have you given needles/works/rinse water or cotton to use after you? (*GR90DPG*)
 - 1. How many of these people were HIV negative or you did not know their HIV status? (*GR90DPGH*)
 - 2. On how many **days** did you give needles/works/rinse water or cotton to be used after you? (*GR90DDG*)
- c. From how many **people** have you taken needles/works/rinse water or cotton to use after them? (*GR90DPT*)
 - 1. How many of these people were HIV negative or you did not know their HIV status? (*GR90DPTH*)
 - 2. On how many **days** did you take needles/works/rinse water or cotton from someone to use after them? (*GR90DDTK*)

<input type="text"/>	(xx Days)
<input type="text"/>	(xx People)
<input type="text"/>	(xx People)
<input type="text"/>	(xx Days)
<input type="text"/>	(xx People)
<input type="text"/>	(xx People)
<input type="text"/>	(xx Days)

The next questions are about having sex. When we refer to sex it includes vaginal, oral and anal sex with anyone. (Vaginal sex is when a man puts his penis into a woman's vagina. Oral sex is when one person puts his or her mouth onto the other person's penis or vagina. Anal sex is when a man puts his penis into another person's anus or butt.)

4. When was the **last** time, if ever, that you **had any kind of vaginal, oral, or anal sex** with another person?(GRLASTSX)

5. During the past 12 months, did you...

- a. Have sex while you **were high on alcohol or on other drugs**?(GRSEXHGH)
- b. Have sex with someone who was an **injection drug user**?(GRSEXINU)
- c. Have sex involving **anal intercourse** (penis to butt)?(GRSEXANL)
- d. Have sex against your will (you were forced or coerced)?(GRSEXAGS)
- e. **Trade** sex to get drugs, gifts or money?(GRSEXTRD)
- f. Use drugs, gifts, or money to **purchase** or get sex?(GRSEXDRG)
- g. Have sex with someone who you thought was **HIV negative** or you did not know their HIV status?(GRSEXNEG)
- h. Have **two or more** different sex partners (not necessarily at the same time)?(GRSEX2PP)
- i. Have sex with a **male partner**?(GRSEXMAL)
- j. Have sex with a **female partner**?(GRSEXFEM)
- k. Have sex **without** using any kind of condom to protect you and your partner from diseases or pregnancy?(GRSEXCND)
- l. Have a lot of **pain** during sex or after having had sex?(GRSEXPAN)
- m. Use alcohol or other drugs to make sex **last longer or hurt less**?(GRSEXLST)

- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes
- ☐ No ☐ Yes

We want to ask you some questions about your sexual partners.

6. During the past 90 days...

- a. How many sex partners did you have who were male?(GR9SXMAL) (xxx Partners)
 How many of your male sex partners were HIV negative or you did not know their HIV status?(GR9SXMHV) (xxx Partners)
- b. How many sex partners did you have who were female?(GR9SXFEM) (xxx Partners)
 How many of your female sex partners were HIV negative or you did not know their HIV status?(GR9SXFHV) (xxx Partners)
- c. With how many of your male or female partners have you been high on alcohol or drugs when having sex at least once in the past 90 days?(GR9SXHGH) (xxx Partners)
- d. Have you had a partner that you consider a primary partner?
 (By primary we mean someone with whom you felt a special emotional commitment, someone you have dated or would call your boyfriend, girlfriend, spouse, significant other or lifetime partner.)
 (GRPRIMPT) ☐ No ☐ Yes
- 1. Your primary partner's gender is:(GRPRIMGN) ☐ Male ☐ Female

2. How long have the two of you been seeing each other?(GRRELTLT)

3. What is your primary partner's HIV status?(GRPRIMHS)

☐ Positive ☐ Negative ☐ Unknown

4. Do you believe this relationship to be exclusive or monogamous (i.e., that neither of you have sex with other partners)?(GRPRIMEX)

☐ No ☐ Yes

5. How many times in the last 12 months did you have any kind of vaginal or anal sex with your primary partner?(GRPRIMSX)

(xxx)

6. How many times when you had any kind of vaginal or anal sex with your primary partner, did you use a condom from start to finish?(GRPRIMCN)

(xxx)

7. How many times when you had anal or vaginal sex with your primary partner, were you high on alcohol or drugs?(GRPRIMHG)

(xxx)

7. **During the past 90 days**, when you had sex with your male and/or female partners (excluding your primary partner, if you had one), how many times...

a. Did you have vaginal or anal sex with HIV positive partners?(GRSEXHVP)

(xxx Times)

b. Did you have vaginal or anal sex with HIV negative or unknown status partners? (GRSEXHVN)

(xxx Times)

Of these, how many times was a condom worn from start to finish? (GRCONDOM)

(xxx Times)

c. Did you have sex while you were **high on alcohol or other drugs**? (GRNPMHGH)

(xxx Times)

d. Did you **trade sex** for drugs, gifts, or money? (GRNPMTRD)

(xxx Times)

e. Use drugs, gifts, or money to purchase or get sex? (GRNPMDRG)

(xxx Times)

Comments:(GRBCOMM)

NIDA Clinical Trials Network

Hepatitis C Questions (HEP)

Web Version: 1.0; 1.01; 08-20-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Now I'm going to ask you a few questions about Hepatitis C.

Date of assessment: (*HEPASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

1. Have you ever been diagnosed with hepatitis C? (*HECDIAG*)

☐ No ☐ Yes

If "Yes", when were you diagnosed with hepatitis C? (*HECDXMO*)

/ (*HECDX*YR, (mm/yyyy)

2. Have you ever been tested for hepatitis C? (*HECTEST*)

☐ No ☐ Yes ☐ Don't know

a. If "Yes", when was the last time that you were tested for hepatitis C? (*HECTSMO*)

/ (*HECTS*YR, (mm/yyyy)

b. If "Yes", when you were last tested for hepatitis C, where did you get tested? (*HECLOC*)

If "Other", specify: (*HELOCSP*)

Comments: (*HEPCOMM*)

Additional Selection Options for HEP

If "Yes" , when you were last tested for hepatitis C, where did you get tested?

- 6-Family planning clinic
- 7-Prenatal or obstetrics clinic
- 8-HIV counseling and testing site
- 9-Other outpatient facility
- 10-Hospital (as an inpatient)
- 11 -Emergency room
- 12-Drug treatment program
- 13-Private doctors office (including HMO)
- 14-Correctional facility (such as jail or prison)
- 15-Blood bank or plasma center
- 16-Military
- 17-At home
- 99-Other

NIDA Clinical Trials Network

Household Food Survey (HFS)

Web Version: 1.0; 1.00; 07-19-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

I will now ask you some questions about your access to food.

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

Date of assessment: (*HFSASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

1. In the past four weeks, did you worry that you would not have enough food? (*HFNFOOD*)

☐ No ☐ Yes

How often did this happen? (*HFHOFTEN*)

2. In the past four weeks, were you not able to eat the kinds of foods you preferred because of a lack of resources?

☐ No ☐ Yes

"Yes" means you were NOT able to eat.

*"No" means you were able to eat. (*HSPREFER*)*

How often did this happen? (*HSPREOFT*)

3. In the past four weeks, did you have to eat a limited variety of foods due to a lack of resources? (*HSVARIET*)

☐ No ☐ Yes

How often did this happen? (*HSVAROFT*)

4. In the past four weeks, did you have to eat some foods that you really did not want to eat because of lack of resources to obtain other types of food? (*HSNOTEAT*)

☐ No ☐ Yes

How often did this happen? (*HSNOTOFT*)

5. In the past four weeks, did you have to eat a smaller meal than you felt you needed because there was not enough food? (*HSSMALLE*)

☐ No ☐ Yes

How often did this happen? (*HSSMAOFT*)

6. In the past four weeks, did you have to eat fewer meals in a day because there was not enough food? (*HSFFEWER*)

☐ No ☐ Yes

How often did this happen?(HSFEWOFT)

7. In the past four weeks, was there ever no food to eat of any kind in your household because of lack of resources to get food?

"Yes" means there was a time when there was NO food.
"No" means there was NEVER a time without food.(HSLACKRE)

How often did this happen?(HSLACKOF)

☐ No ☐ Yes

8. In the past four weeks, did you go to sleep at night hungry because there was not enough food?(HSNOTFOO)

How often did this happen?(HSNIGOFT)

☐ No ☐ Yes

9. In the past four weeks, did you go a whole day and night without eating anything because there was not enough food?(HFWHOLED)

How often did this happen?(HFWHOFT)

☐ No ☐ Yes

Comments:(HFSCOMM)

NIDA Clinical Trials Network

Health Literacy (HLT)

Web Version: 1.0; 1.00; 08-20-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

The next set of questions has to do with reading health/medical forms and materials.

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

Date of assessment: (*HLTASMDT*)

(mm/dd/yyyy) [Click here to view calendar](#)

1. How often do you have someone help you read hospital materials? (*HLHOSMAT*)

2. How confident are you filling out medical forms by yourself? (*HLMEDFRM*)

3. How often do you have problems learning about your medical condition because of difficulty understanding written information? (*HLWRTINF*)

Comments: (*HLTCOMM*)

NIDA Clinical Trials Network

Initial Hospital Admission (IHA)

Web Version: 1.0; 3.01; 12-13-13

Segment (**PROTSEG**):

Visit Number (**VISNO**):

The following questions are about your current hospital stay/admission.

Date of admission: (**IHAASMDT**)

(mm/dd/yyyy) [Click here for calendar](#)

1. Primary diagnosis for admission: (**IHPRIMDX**)

Comorbid diagnoses, excluding HIV: (**IHCOMDX1**)

(**IHCOMDX2**)

(**IHCOMDX3**)

(**IHCOMDX4**)

(**IHCOMDX5**)

(**IHCOMDX6**)

(**IHCOMDX7**)

2. Was the participant on ARVs prior to admission? (**IHONART**)

If "Yes," add meds to the ARV Med log.

☐ No ☐ Yes

3. Was the participant started on ARVs during admission? (**IHSTART**)

If "Yes," add meds to the ARV Med log.

☐ No ☐ Yes

4. Did the participant die during the initial hospital admission? (**IHDIED**)

☐ No ☐ Yes

5. Referrals given to:

Case management (**IHREFCM**) ☐ No ☐ Yes

Housing (**IHREFH**) ☐ No ☐ Yes

Mental health (**IHREFMH**) ☐ No ☐ Yes

Drug treatment (**IHREFDR**) ☐ No ☐ Yes

Outpatient HIV clinic (**IHREFOHC**) ☐ No ☐ Yes

Other outpatient specialty care (**IHREFOOS**) ☐ No ☐ Yes

6. Was the participant discharged with a supply of ARVs? (**IHMEDSUP**)

If "Yes," how many days supply? (**IHDAYSUP**)

☐ No ☐ Yes

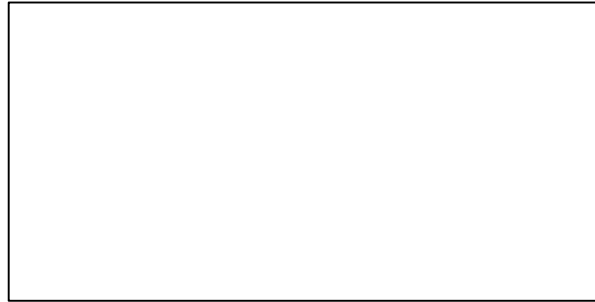
(xxx) Days

7. Discharge date: (**IHDISDT**)

(mm/dd/yyyy) [Click here for calendar](#)

8. Discharge diagnosis: (**IHDISDX**)

Comments: (IHA COMM)



NIDA Clinical Trials Network

Modified Illegal Activities (MIA)

Web Version: 1.0; 3.01; 11-26-13

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Date of assessment: (*MIASMTDT*)

(mm/dd/yyyy) [Click here for calendar](#)

Have you ever been arrested? (*MIARREST*)

☐ No ☐ Yes

Have you been arrested in the last 6 months? (*MIARST6M*)

☐ No ☐ Yes

Have you ever been incarcerated? (*MIINCARC*)

☐ No ☐ Yes

Have you been incarcerated in the last 6 months? (*MIINCA6M*)

☐ No ☐ Yes

How many days have you been incarcerated in your lifetime? (*MIINLFDY*)

(xxxx)

How many days have you been incarcerated in the past 6 months? (*MIIN6MDY*)

(xxx)

The next several questions are about illegal activities.

Illegal Activities

1. Have you ever been intoxicated (high or drunk) from alcohol or drugs in public? (*MIIPUB*)

☐ No ☐ Yes

a. How many times in the past 6 months have you been intoxicated (high or drunk) from alcohol or drugs in public? (*MIITX16M*)

(xxx)

b. How old were you the first time you were intoxicated (high or drunk) from alcohol or drugs in public? (*MIITXIAG*)

(xx)

c. Have you ever been arrested for public intoxication? (*MIARSTTO*)

☐ No ☐ Yes

d. How many times in the past 6 months have you been arrested for being intoxicated from alcohol or drugs in public? (*MIITXA6M*)

(xxx)

e. How old were you the first time you were arrested for being intoxicated from alcohol or drugs in public? (*MIITXAAG*)

(xx)

2. Have you ever driven under influence of alcohol or drugs? (*MIADUI*)

☐ No ☐ Yes

a. How many times in the past 6 months have you driven under the influence of alcohol or drugs? (*MIDUI16M*)

(xxx)

b. How old were you the first time you drove under the influence of alcohol or drugs? (*MIDUI1AG*)

(xx)

c. Have you ever been arrested for driving under the influence of alcohol? (*MIARDUI*)

☐ No ☐ Yes

d. How many times in the past 6 months have you been arrested for driving under the influence of alcohol or drugs? (*MIDUIA6M*)

(xxx)

e. How old were you the first time you were arrested for driving while under the influence of alcohol or drugs in public? (*MIDUIAAG*)

(xx)

3. Have you ever used or possessed illegal drugs? (*MIAPOS*)

☐ No ☐ Yes

a. How many times in the past 6 months have you used or possessed illegal drugs? (*MIPOS16M*)

(xxx)

b. How old were you the first time you used or possessed illegal drugs? (*MIPOS1AG*)

(xx)

c. Have you ever been arrested for using or possessing illegal drugs? (*MIARPOSS*)

☐ No ☐ Yes

d. How many times in the past 6 months have you been arrested for using or possessing illegal drugs? (*MIPOSA6M*)

(xxx)

e. How old were you the first time you were arrested for using or possessing illegal drugs? (*MIPOSAAG*)

(xx)

4. Have you ever had possession with intent to distribute? *(MIIADST)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you possessed illegal drugs with the intent to distribute? *(MIDSTI6M)* (xxx)
- b. How old were you the first time you possessed illegal drugs with the intent to distribute? *(MIDSTIAG)* (xx)
- c. Have you ever been arrested for possession of drugs with the intent to distribute? *(MIARDIST)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for possession of illegal drugs with the intent to distribute? *(MDSTA6M)* (xxx)
- e. How old were you the first time you were arrested for possession of illegal drugs with the intent to distribute? *(MIDSTAAG)* (xx)
5. Have you ever had possession of drug paraphernalia? *(MIIAPAR)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you possessed drug paraphernalia? *(MIPARI6M)* (xxx)
- b. How old were you the first time you possessed drug paraphernalia? *(MIPARIAG)* (xx)
- c. Have you ever been arrested for possession of drug paraphernalia? *(MIARPARA)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for possession of drug paraphernalia? *(MIPARA6M)* (xxx)
- e. How old were you the first time you were arrested for possession of drug paraphernalia? *(MIPARAAG)* (xx)
6. Have you ever manufactured or grown drugs? *(MIIAGRW)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you manufactured or grown drugs? *(MIGRWI6M)* (xxx)
- b. How old were you the first time you were involved with manufacturing or growing drugs? *(MIGRWIAG)* (xx)
- c. Have you ever been arrested for manufacturing or growing drugs? *(MIARGROW)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for manufacturing or growing drugs? *(MIGRWA6M)* (xxx)
- e. How old were you the first time you were arrested for manufacturing or growing drugs? *(MIGRWAAG)* (xx)
7. Have you ever sold or distributed drugs? *(MIIASAL)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in the sale or distribution of drugs? *(MISALI6M)* (xxx)
- b. How old were you the first time you sold or distributed drugs? *(MISALIAG)* (xx)
- c. Have you ever been arrested for the sale or distribution of drugs? *(MIARSALE)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for selling or distributing drugs? *(MISALA6M)* (xxx)
- e. How old were you the first time you were arrested for being involved in the sale or distribution of drugs? *(MISALAAG)* (xx)
8. Have you ever been involved in forgery or fraud (bad checks, credit card fraud, etc.)? *(MIIAFRD)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in forgery/fraud (bad checks, credit card fraud, etc.)? *(MIFRDI6M)* (xxx)
- b. How old were you the first time you were involved in forgery/fraud (bad checks, credit card fraud, etc.)? *(MIFRDIAG)* (xx)
- c. Have you ever been arrested for forgery or fraud (bad checks, credit card fraud, etc.)? *(MIARFRD)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for forgery/fraud (bad checks, credit card fraud, etc.)? *(MIFRDA6M)* (xxx)
- e. How old were you the first time you were arrested for forgery/fraud (bad checks, credit card fraud, etc.)? *(MIFRDAAG)* (xx)
9. Have you ever been involved in fencing (buying or selling stolen property)? *(MIIAFEN)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in fencing (buying or selling stolen property)? *(MIFENI6M)* (xxx)

- b. How old were you the first time you were involved in fencing (buying or selling stolen property)? *(MIFENIAG)* (xx)
- c. Have you ever been arrested for fencing (buying or selling stolen property)? *(MIARFENC)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for fencing (buying or selling stolen property)? *(MIFENA6M)* (xxx)
- e. How old were you the first time you were arrested for fencing (buying or selling stolen property)? *(MIFENAAG)* (xx)
10. Have you ever been involved in illegal gambling (running numbers)? *(MIIAGAM)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in illegal gambling (running numbers)? *(MIGAMI6M)* (xxx)
- b. How old were you the first time you were involved in illegal gambling (running numbers)? *(MIGAMIAG)* (xx)
- c. Have you ever been arrested for illegal gambling (running numbers)? *(MIARGAMB)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for illegal gambling (running numbers)? *(MIGAMA6M)* (xxx)
- e. How old were you the first time you were arrested for illegal gambling (running numbers)? *(MIGAMAAG)* (xx)
11. Have you ever been involved in prostitution or pimping? *(MIIAPRS)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in prostitution or pimping? *(MIPRSI6M)* (xxx)
- b. How old were you the first time you were involved in prostitution or pimping? *(MIPRSIAG)* (xx)
- c. Have you ever been arrested for prostitution or pimping? *(MIARPRS T)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for prostitution or pimping? *(MIPRSA6M)* (xxx)
- e. How old were you the first time you were arrested for being involved in prostitution or pimping? *(MIPRSAAG)* (xx)
12. Have you ever been involved in burglary/attempted burglary/breaking and entering (home, auto, business)? *(MIIABAE)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in burglary/attempted burglary/breaking and entering (home, auto, business)? *(MIBAEI6M)* (xxx)
- b. How old were you the first time you were involved in burglary/attempted burglary/breaking and entering (home, auto, business)? *(MIBAEIAG)* (xx)
- c. Have you ever been arrested for burglary/attempted burglary/breaking and entering (home, auto, business)? *(MIARBURG)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for being involved in burglary/attempted burglary/breaking and entering (home, auto, business)? *(MIBAEA6M)* (xxx)
- e. How old were you the first time you were arrested for being involved in burglary/attempted burglary/breaking and entering (home, auto, business)? *(MIBAEAAG)* (xx)
13. Have you ever been involved in shoplifting/larceny/embezzlement? *(MIIALAR)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in shoplifting/larceny/embezzlement? *(MILARI6M)* (xxx)
- b. How old were you the first time you were involved in shoplifting/larceny/embezzlement? *(MILARIAG)* (xx)
- c. Have you ever been arrested for shoplifting/larceny/embezzlement? *(MIARLARC)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for shoplifting/larceny/embezzlement? *(MILARA6M)* (xxx)
- e. How old were you the first time you were arrested for shoplifting/larceny/embezzlement? *(MILARAAG)* (xx)
14. Have you ever been involved in auto theft/carjacking? *(MIIACAR)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in auto theft/carjacking? *(MICARI6M)* (xxx)
- b. How old were you the first time you were involved in auto theft/carjacking? *(MICARIAG)* (xx)
- c. Have you ever been arrested for auto theft/carjacking? *(MIARCAR)* ☐ No ☐ Yes

- d. How many times in the past 6 months have you been arrested for a uto theft/carjacking? (MICARA6M) (xxx)
- e. How old were you the first time you were arrested for auto theft/carjacking? (MICARAAG) (xx)
15. Have you ever been involved in robbery/attempted robbery/mugging? (MIAROB) ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in robbery/attempted robbery/mugging? (MIROBI6M) (xxx)
- b. How old were you the first time you were involved in robbery/attempted robbery/mugging? (MIROBIAG) (xx)
- c. Have you ever been arrested for robbery/attempted robbery/mugging? (MIARROB) ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for robbery/attempted robbery/mugging? (MIROBA6M) (xxx)
- e. How old were you the first time you were arrested for robbery/attempted robbery/mugging? (MIROBAAG) (xx)
16. Have you ever been involved in assault/aggravated assault/battery (does not include rape or sexual assault)? (MIAAAB) ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in assault/aggravated assault/battery (does not include rape or sexual assault)? (MIAAB6M) (xxx)
- b. How old were you the first time you were involved in assault/aggravated assault/battery (does not include rape or sexual assault)? (MIAABIAG) (xx)
- c. Have you ever been arrested for assault/aggravated assault/battery (does not include rape or sexual assault)? (MIARAAB) ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for assault/aggravated assault/battery (does not include rape or sexual assault)? (MIAABA6M) (xxx)
- e. How old were you the first time you were arrested for assault/aggravated assault/battery (does not include rape or sexual assault)? (MIAABAAAG) (xx)
17. Have you ever been involved in kidnapping/hostage taking? (MIIAKID) ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in kidnapping/hostage taking? (MIKIDI6M) (xxx)
- b. How old were you the first time you were involved in kidnapping/hostage taking? (MIKIDIAG) (xx)
- c. Have you ever been arrested for kidnapping/hostage taking? (MIARKID) ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for kidnapping/hostage taking? (MIKIDA6M) (xxx)
- e. How old were you the first time you were arrested for kidnapping/hostage taking? (MIKIDAAG) (xx)
18. Have you ever been involved in terrorist threats/acts? (MIATER) ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in terrorist threats/acts? (MITERI6M) (xxx)
- b. How old were you the first time you were involved in terrorist threats/acts? (MITERIAG) (xx)
- c. Have you ever been arrested for terrorist threats/acts? (MIARTER) ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for terrorist threats/acts? (MITERA6M) (xxx)
- e. How old were you the first time you were arrested for terrorist threats/acts? (MITERAAG) (xx)
19. Have you ever been involved in homicide/manslaughter/attempted homicide? (MIIAHOM) ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in homicide/manslaughter/attempted homicide? (MIHOMI6M) (xxx)
- b. How old were you the first time you were involved in homicide/manslaughter/attempted homicide? (MIHOMIAG) (xx)
- c. Have you ever been arrested for homicide/manslaughter/attempted homicide? (MIARHOM) ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for homicide/manslaughter/attempted homicide? (MIHOMA6M) (xxx)
- e. How old were you the first time you were arrested for homicide/manslaughter/attempted homicide? (MIHOMAAG) (xx)

20. Have you ever been involved in arson offenses? *(MIIAARS)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in arson offenses? *(MIARS6M)* (xxx)
- b. How old were you the first time you were involved in arson offenses? *(MIARSIAG)* (xx)
- c. Have you ever been arrested for an arson offense? *(MIARARS)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for arson offenses? *(MIARSA6M)* (xxx)
- e. How old were you the first time you were arrested for arson offenses? *(MIARSAAG)* (xx)
21. Have you ever been involved in weapons offenses? *(MIIA WEP)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in weapons offenses? *(MIWEPI6M)* (xxx)
- b. How old were you the first time you were involved in weapons offenses? *(MIWEPIAG)* (xx)
- c. Have you ever been arrested for a weapons offense? *(MIARWEP)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for weapons offenses? *(MIWEPA6M)* (xxx)
- e. How old were you the first time you were arrested for weapons offenses? *(MIWEPAAG)* (xx)
22. Have you ever been involved in vandalism/property damage/tagging? *(MIIAVAN)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved with vandalism/property damage/tagging? *(MIVANI6M)* (xxx)
- b. How old were you the first time you were involved in vandalism/property damage/tagging? *(MIVANIA G)* (xx)
- c. Have you ever been arrested for vandalism/property damage/tagging? *(MIARVAN)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for vandalism/property damage/tagging? *(MIVANA6M)* (xxx)
- e. How old were you the first time you were arrested for vandalism/property damage/tagging? *(MIVANAAG)* (xx)
23. Have you ever been involved in sex offenses (rape/aggravated assault/sex with a minor)? *(MIIASEX)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in a sex offense (rape/aggravated assault/sex with a minor)? *(MISEX6M)* (xxx)
- b. How old were you the first time you were involved in a sex offense (rape/aggravated assault/sex with a minor)? *(MISEXIAG)* (xx)
- c. Have you ever been arrested for a sex offense (rape/aggravated assault/sex with a minor)? *(MIARSEX)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for a sex offense (rape/aggravated assault/sex with a minor)? *(MISEXA6M)* (xxx)
- e. How old were you the first time you were arrested for a sex offense (rape/aggravated assault/sex with a minor)? *(MISEXAAG)* (xx)
24. Have you ever been involved in probation/parole violations? *(MIIAPRB)* ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in probation/parole violations? *(MIPRB6M)* (xxx)
- b. How old were you the first time you were involved in probation/parole violations? *(MIPRBIAG)* (xx)
- c. Have you ever been arrested for probation/parole violation? *(MIA RPRB)* ☐ No ☐ Yes
- d. How many times in the past 6 months have you been arrested for probation/parole violations? *(MIPRBA6M)* (xxx)
- e. How old were you the first time you were arrested for probation/parole violations? *(MIPRBAAG)* (xx)
25. Have you ever been involved in other crimes not listed above?
If "Yes", specify in comments (MIIAOTH) ☐ No ☐ Yes
- a. How many times in the past 6 months have you been involved in this crime? *(MIOTH6M)* (xxx)
- b. How old were you the first time you were involved in this crime? *(MIOTHIAG)* (xx)

c. Have you ever been arrested for other crimes not listed above?*(MIAROTH)*
d. How many times in the past 6 months have you been arrested for this crime?*(MIO THA6M)*
e. How old were you the first time you were arrested for this crime? *(MIO THAAG)*

☐ No☐ Yes

(xxx)

(xx)

Comments:*(MIACOMM)*

NIDA Clinical Trials Network

History of Abuse and Interpersonal Violence (MIV)

Web Version: 1.0; 2.00; 06-20-13

Segment (*PROTSEG*):

Visit Number (*VISNO*):

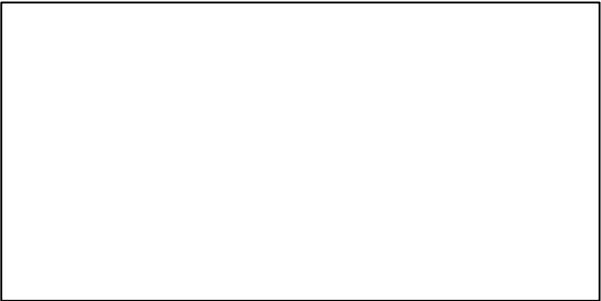
The next questions are about abuse and interpersonal violence. Please let me know if you would like to stop at any point. As a study interviewer, I am not permitted to discuss any specific incidents of abuse with you, but there is someone on hand who can talk with you if you'd like to do so.

Date of assessment:(*MIVASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

1. As a child, were you ever beaten, physically attacked, or physically abused? (*MICHATCK*)
☐ No ☐ Yes ☐ Refuse to answer
2. As a child, were you ever sexually attacked, raped, or sexually abused? (*MICHABUS*)
☐ No ☐ Yes ☐ Refuse to answer
3. As an adult, have you ever been beaten, physically attacked, or physically abused? (*MIADATCK*)
☐ No ☐ Yes ☐ Refuse to answer
4. Have you been beaten, physically attacked, or physically abused since your last visit? (*MIADATCK*)
Were you ever in a relationship where a sexual partner did this to you? (*MIPRTATK*)
☐ No ☐ Yes ☐ Refuse to answer
Were you in a relationship where a sexual partner did this to you? (*MIPRTATK*)
☐ No ☐ Yes ☐ Refuse to answer
5. As an adult, have you ever been sexually attacked, raped, or sexually abused? (*MIADABUS*)
☐ No ☐ Yes ☐ Refuse to answer
6. Have you been sexually attacked, raped, or sexually abused since your last visit? (*MIADABUS*)
Were you ever in a relationship where a sexual partner did this to you? (*MIPRTABU*)
☐ No ☐ Yes ☐ Refuse to answer
Were you in a relationship where a sexual partner did this to you? (*MIPRTABU*)
☐ No ☐ Yes ☐ Refuse to answer
7. Have you ever been in a relationship where a sexual partner threatened you with violence? (*MITHREAT*)
☐ No ☐ Yes ☐ Refuse to answer
8. Have you been in a relationship where a sexual partner threatened you with violence since your last visit? (*MITHREAT*)
☐ No ☐ Yes ☐ Refuse to answer
9. Have you ever been in a relationship where a sexual partner threw, broke, or punched things? (*MIPUNCHD*)
☐ No ☐ Yes ☐ Refuse to answer
10. Have you been in a relationship where a sexual partner threw, broke, or punched things since your last visit? (*MIPUNCHD*)
☐ No ☐ Yes ☐ Refuse to answer
11. Have you ever been in a relationship where you felt controlled by a sexual partner? (*MICONTRL*)
☐ No ☐ Yes ☐ Refuse to answer
12. Have you been in a relationship where you felt controlled by a sexual partner since your last visit? (*MICONTRL*)
☐ No ☐ Yes ☐ Refuse to answer

Comments:(MIVCOMM)



NIDA Clinical Trials Network

Medical Mistrust (MMT)

Web Version: 1.0; 1.00; 07-23-12

Segment (PROTSEG):

Visit Number (VISNO):

Now I'm going to read a series of statements to you about health care and the experiences of people of your racial/ethnic group with the health care system.

Please tell me how much you agree or disagree with each statement on a scale of 1 to 5 where 1= strongly disagree...and 5= strongly agree.

RA Instruction: Provide participant with a reference card that lists all 5 response options for his/her easy reference.

Date of assessment: (MMTASMDT)

(mm/dd/yyyy) [Click here for calendar](#)

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. Doctors and health care workers sometimes hide information from patients who belong to my ethnic group.	(MMHIDE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Doctors have the best interests of people of my ethnic group in mind.	(MMBEST) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. People of my ethnic group should not confide in doctors and health care workers because it will be used against them.	(MMCONF) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. People of my ethnic group should be suspicious of information from doctors and health care workers.	(MMSUSPI) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. People of my ethnic group cannot trust doctors and health care workers.	(MMTRUST) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. People of my ethnic group should be suspicious of modern medicine.	(MMMEDIC) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Doctors and health care workers treat people of my ethnic group like "guinea pigs".	(MMGUINE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. People of my ethnic group receive the same medical care from doctors and health care workers as people from other groups.	(MMSAME) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Doctors and health care workers do not take the medical complaints of people of my ethnic group seriously.	(MMCOMPL) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. People of my ethnic group are treated the same as people of other groups by doctors and health care workers.	(MMTREAT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In most hospitals, people of different ethnic groups receive the same kind of care.	(MMHOSP) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I have personally been treated poorly or unfairly by doctors or health care workers because of my ethnicity.	(MMPERSO) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In a health care setting have you ever experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior because of your:

	No	Yes	Don't Know	Refuse to Answer
1. HIV status?	(MMHIV) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Gender?	(MMGENDE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Sexual orientation or practices?	(MMORIEN) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Race or ethnicity?	(MMRACE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Drug use?	(MMDRUG) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: (MMTCOMM)

NIDA Clinical Trials Network

Readiness for Substance Use Treatment (MTT)

Web Version: 1.0; 1.00; 03-21-12

Segment (*PROTSEG*):

Visit Number (VISNO):

Date of assessment: (MTTASMDT)

Page 10 of 10

(mm/dd/yyyy) [Click here for calendar](#)

The following questions ask about "substances". By "substance" we mean drugs or alcohol.

1. Treatment could be your last chance to solve your substance use problems. (MTLASTC)

--

2. If you enter treatment, you will stay for a while. (*MTSTAY*)

--	--

3. Treatment could really help you. (MTCOULDH)

--	--

4. You want to be in a treatment program. (M TWANTIN)

--

5. Most counselors in substance use treatment programs are "squares" who don't understand substance users. (MTCOUNS)

--	--

6. Substance use treatment programs have too many rules and regulations for me. (MTTOORUL)

7. I don't think I could trust many of the people who work in the substance use treatment programs.
(MTTRUST)

8. It takes too much time and effort to get into a substance use treatment program.(MTTOOTIM)

Comments:(MTTCOMM)

NIDA Clinical Trials Network

Non-Intervention Tracking and Contact (NIT)

Web Version: 1.0; 3.01; 09-11-13

Segment (*PROTSEG*):
Tracking log number (*NITLOGNM*):

Tracking Log

Record each tracking activity separately. Tracking activities include any non-intervention-related contact (whether staff or participant initiated), attempt to contact, or effort to find contact information with the intention of scheduling the partici

Date (mm/dd/yyyy)	Day (of Week)	Start Time (hh:mm)	End Time (hh:mm)	Length of Time (Minutes) (xxx)	Activity
(NIA C01DT) Calendar	(NIDAY01)	(NISTM01)	(NIETM01)	(NILENG01)	(NIDESC01)
(NIA C02DT) Calendar	(NIDAY02)	(NISTM02)	(NIETM02)	(NILENG02)	(NIDESC02)
(NIA C03DT) Calendar	(NIDAY03)	(NISTM03)	(NIETM03)	(NILENG03)	(NIDESC03)
(NIA C04DT) Calendar	(NIDAY04)	(NISTM04)	(NIETM04)	(NILENG04)	(NIDESC04)
(NIA C05DT) Calendar	(NIDAY05)	(NISTM05)	(NIETM05)	(NILENG05)	(NIDESC05)
(NIA C06DT) Calendar	(NIDAY06)	(NISTM06)	(NIETM06)	(NILENG06)	(NIDESC06)
(NIA C07DT) Calendar	(NIDAY07)	(NISTM07)	(NIETM07)	(NILENG07)	(NIDESC07)
(NIA C08DT) Calendar	(NIDAY08)	(NISTM08)	(NIETM08)	(NILENG08)	(NIDESC08)
(NIA C09DT) Calendar	(NIDAY09)	(NISTM09)	(NIETM09)	(NILENG09)	(NIDESC09)
(NIA C10DT)	(NIDAY10)	(NISTM10)	(NIETM10)	(NILENG10)	(NIDESC10)

Calendar					
--------------------------	--	--	--	--	--

Comments:(*NITCOMM*)

Additional Selection Options for NIT

Tracking log number (*NITLOGNM*) (key field):

- 01 -1st log
- 02 -2nd log
- 03 -3rd log
- 04 -4th log
- 05 -5th log
- 06 -6th log
- 07 -7th log
- 08 -8th log
- 09 -9th log
- 10 -10th log
- 11 -11th log
- 12 -12th log
- 13 -13th log
- 14 -14th log
- 15 -15th log
- 16 -16th log
- 17 -17th log
- 18 -18th log
- 19 -19th log
- 20 -20th log
- 21 -21st log
- 22 -22nd log
- 23 -23rd log
- 24 -24th log
- 25 -25th log
- 26 -26th log
- 27 -27th log
- 28 -28th log
- 29 -29th log
- 30 -30th log

NIDA Clinical Trials Network

Perceived Health Status SF-12 (PHS)

Web Version: 1.0; 1.00; 07-10-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Date of assessment: (*PHSASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

RA Instruction: Provide participant with reference cards for each question that list all response options for his/her easy reference.

This survey asks for your views about your health. Please select the response that best describes your answer. This information will help keep track of how you feel and how well you are able to do your usual activities. Thank you for completing this survey!

For each of the following questions, please check the box that best describes your answer.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
(<i>PHHEALTH</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:	(<i>PHMODACT</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Climbing <u>several</u> flights of stairs:	(<i>PHSTAIRS</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <u>Accomplished less</u> than you would like:	(<i>PHPACCOMP</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were limited in the <u>kind</u> of work or other activities:	(<i>PHPKDWK</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of	Most of	Some of	A little	None of

	the time	the time	the time	of the time	the time
a. <u>Accomplished less</u> than you would like:	(PHEACCMP) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Did work or other activities <u>less carefully than usual</u> :	(PHEWORK) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
(PHNRMWRK) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	(PHCALM) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Did you have a lot of energy?	(PHENERGY) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt downhearted and depressed?	(PHDEPRSS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
(PHSOCIAL) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THANK YOU FOR COMPLETING THESE QUESTIONS!

12. Understanding the problems you have taking your antiretroviral medicines?	(PPARPRBM) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Helping you solve problems you have taking your antiretroviral medicines right away?	(PPARSOLV) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Participatory decision-making

RA Instruction: Provide participant with reference cards for subsequent items (as those items are read to the participant) that list all response options for his/her easy reference.

	Very often	Often	Sometimes	Rarely	Never
14. How often does the health care provider who takes care of your HIV infection ask you to take some of the responsibility for your treatment?	(PPRSPTRT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Definitely yes	Probably yes	Uncertain	Probably not	Definitely not
15. If there was a choice between treatments, would the health care provider who takes care of your HIV infection ask you to help make the decision?	(PPHELPDE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Very often	Often	Sometimes	Rarely	Never
16. How often does the health care provider who takes care of your HIV infection make an effort to give you some control over treatment decisions?	(PPTREAT) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often does the health care provider who takes care of your HIV infection do the following things:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
17. Offer choices in your medical care?	(PPOFFER) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Discuss the pros and cons of each choice with you?	(PPPROCON) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Get you to state which choice or option you would prefer?	(PPSTATE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Take your preferences into account when making treatment decisions?	(PPPPREFER) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall satisfaction with health care provider

How would you rate the health care provider who takes care of your HIV infection in each of the following:

	Excellent	Very good	Good	Fair	Poor
21. Personal manner - courtesy, respect, sensitivity, friendliness:	(PPPERSON) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Communication skills - listening carefully, answering questions, giving clear explanations:	(PPCOMMU) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Technical skills - thoroughness, carefulness, competence:	(PPTECHN) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Your health care provider's overall care:	(PPOVERAL) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Willingness to recommend

	Definitely will not	Probably will not	Not sure	Probably will	Definitely will
25. Do you plan to continue to see the health care provider who takes care of your HIV infection in the future?	(PPCTNSEE) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you plan to recommend the health care provider who takes care of your HIV infection to others?	(PPRECOMM) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Trust in health care provider

Thinking about how much you trust your health care provider, how strongly do you agree or disagree with the following statements?

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
27. I can tell my health care provider anything, even things that I might not tell anyone else.	(PPTELLDR) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. My health care provider cares more about holding down costs than about doing what is needed for my health.	(PPDRCOST) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. My health care provider cares as much as I do about my health.	(PPDRHLTH) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. If a mistake was made in my treatment, my health care provider would try to hide it from me.	(PPTXMIS) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. All things considered, how much do you trust your health care provider?

Least trust possible										Most trust possible
1	2	3	4	5	6	7	8	9	10	
(PPTRUST) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:(PPRCOMM)

NIDA Clinical Trials Network

Pre-Screen Assessment (PSA)

Web Version: 1.0; 1.04; 01-20-15

Pre-Screen ID (PRESCNID):

1. Date of assessment: (PSAASMDT)

(mm/dd/yyyy) [Click here for calendar](#)

2. Has the participant had an AIDS defining illness during the current hospital admission? (PSAIDS)

☐ No ☐ Yes

If "Yes", specify: (PSAIDSSP)

3. What is participant's most recent viral load within the past 12 months? (PSLOADVL)

(xxxxxxx) copies/mL -OR- (PSVRUNK) ☐ Unknown

Unknown should be checked if no evidence of a viral load value exists in past 12 months.

a. Is this viral load at the lower limit? (PSVLLIMIT)

☐ No ☐ Yes

b. Date viral load obtained: (PSLOADDT)

(mm/dd/yyyy) [Click here for calendar](#)

4. What is the participant's most recent CD4 count within the past 12 months? (PSCD4VAL)

(xxxxx) cells/ μ L -OR- (PSCD4UNK) ☐ Unknown

Unknown should be checked if no evidence of CD4 count exists in past 12 months.

a. Date CD4 count obtained: (PSCD4DT)

(mm/dd/yyyy) [Click here for calendar](#)

5. If the participant's most recent CD4 count is less than or equal to 500 cells/ μ L and viral load is greater than 200 copies/mL or unknown within the past 12 months:

a. Per Site PI discretion/judgment, is the participant likely to currently have a viral load greater than 200 copies per mL? (PSPIVL)

☐ No ☐ Yes

b. Per Site PI discretion/judgment, is the participant currently NOT successfully/correctly taking ART? (PSPIART1)

☐ No ☐ Yes

c. Per Site PI discretion/judgment, does the participant need to be on ART? (PSPIART2)

☐ No ☐ Yes

6. How old is the participant? (PSAAGE)

7. What is the participant's gender? (PSGENDER)

8. What is the participant's ethnicity?(PSETHNCT)

9. What is the participant's race:

American Indian or Alaska Native:(PSINDIAN)

Asian:(PSASIAN)

Black or African American:(PSBLACK)

Native Hawaiian or Pacific Islander:(PSHAWAII)

White:(PSWHITE)

Other:(PSRACEOT)

-OR-

Unknown:(PSRACEUK)

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

Specify:(PSRACESP,

☐ Yes

10. Is patient covered by health insurance or some other kind of health care plan?(PSINSURE)

☐ No ☐ Yes

Is the participant eligible?(PSELIGIB)

☐ No ☐ Yes

Comments:(PSACOMM)

Additional Selection Options for PSA

If "Yes", specify:

- 6-Burkitt's lymphoma
- 7-Immunoblastic lymphoma
- 8-Primary CNS lymphoma
- 9-Mycobacterium avium complex or Mycobacterium kansasii
- 10-Other mycobacterium (disseminated, extrapulm)
- 11-M. Tuberculosis (any site)
- 12-Pneumocystis jirovecii pneumonia
- 13-Isosporiasis
- 14-Progressive multifocal leukoencephalopathy
- 15-Recurrent salmonella septicemia
- 16-Toxoplasmosis of the brain
- 17-Wasting syndrome due to HIV
- 18-Invasive cervical cancer
- 19-Recurrent pneumonia

How old is the participant?

- 6-65 to less than 75
- 7-Greater than 75

NIDA Clinical Trials Network

Protocol Violation Log (PVL)

Web Version: 1.0; 3.04; 10-04-12

Date of Violation (PVDATE):

Protocol Violation Number (PVSEQNUM):

To be filled in by person(s) reporting this protocol violation:

1. Violation type:(PVTTYPE49)

If "Other" is indicated, provide the specification: (PVTPSP49)

[illegible]

2. Description of violation: (PVDESC)

[illegible]

3. Has this protocol violation been resolved? (*PVRESOL*)

☐ No ☐ Yes

Protocol violation resolution and corrective action:(PVRSCASP)

4. Does this protocol violation require IRB reporting?(PVIRB)

☐ No ☐ Yes

If "Yes", provide date reported:(PVIRBDT)

 (mm/dd/yyyy) [Click here for calendar](#)

Comments:(PVLCOMM)

Additional Selection Options for PVL

Protocol Violation Number (*PVSEQNUM*) (key field):

01 -1st Protocol Violation of the day
02 -2nd Protocol Violation of the day
03 -3rd Protocol Violation of the day
04 -4th Protocol Violation of the day
05 -5th Protocol Violation of the day
06 -6th Protocol Violation of the day
07 -7th Protocol Violation of the day
08 -8th Protocol Violation of the day
09 -9th Protocol Violation of the day
10 -10th Protocol Violation of the day

Violation type:

01 Z-Other (specify)
02-INCLUSION / EXCLUSION CRITERIA
03-CONCOMITANT MEDICATION/ THERAPY
Z04-LABORATORY ASSESSMENT /PROCEDURES
04 A- Required testing not obtained
04 B-Testing completed outside window
04 C- Testing not completed as per protocol
04 D- Unauthorized test/procedure obtained
04 Z- Other (specify)
Z05- OTHER PROCEDURES / ASSESSMENTS
05 A- Protocol required procedures not obtained
05 B-Procedures / assessments not completed as per protocol
05 C- Procedures / assessments obtained outside the visit timeframe
05 Z- Other (specify)
Z07-RANDOMIZATION PROCEDURES
07 A- Randomization procedures not followed (e.g. outside window, out of sequence, etc.)
07 B-Ineligible participant randomized
07 E-Incorrect treatment assignment
07 Z- Other (specify)
Z09-BEHAVORAL INTERVENTION
09 A- Intervention not provided per protocol schedule or visit window timeframe
09 B-Incorrect intervention assignment
09 Z- Other (specify)
Z10- VISIT SCHEDULE / INTERVAL
10 A- Visit conducted outside of window
10 Z- Other (specify)
Z99- OTHER SIGNIFICANT VIOLATIONS
99 A-Destroying study materials prior to authorization from Lead Node and other appropriate parties
99 B-Participating site starting the study prior to obtaining appropriate IRB(s) and/or CTM approvals
99 C-Using advertising materials or brochures without prior IRB approval
99 Z- Other (specify)

Protocol Violation Review (PVR)

Date of Violation (PVDATE):
Protocol Violation Number (PVSEQNUM):

- 1. Is this event considered to be: (PVSEVER)
- 2. What section of the protocol does this event refer to? (PVSECTN)
- 3. Does this event require retraining? (PVTRAIN)
- 4. Does the protocol need to be modified based on this event? (PVPRTMOD)
- 5. Does the consent need to be modified based on this event? (PVCNTMOD)
- 6. Is the review of this event complete? (PVREVCMP)
If "No", what additional information is requested? (PVADTINF)

☐ Major ☐ Minor

☐ No ☐ Yes
☐ No ☐ Yes
☐ No ☐ Yes
☐ No ☐ Yes

Assessed by: (PVREVBV)

Comments: (PVCOMM)

Additional Selection Options for PVR

Protocol Violation Number (*PVSEQNUM*) (key field):

- 01 -1st Protocol Violation of the day
- 02 -2nd Protocol Violation of the day
- 03 -3rd Protocol Violation of the day
- 04 -4th Protocol Violation of the day
- 05 -5th Protocol Violation of the day
- 06 -6th Protocol Violation of the day
- 07 -7th Protocol Violation of the day
- 08 -8th Protocol Violation of the day
- 09 -9th Protocol Violation of the day
- 10 -10th Protocol Violation of the day

NIDA Clinical Trials Network

Recruitment Ledger (RCT)

Web Version: 1.0; 4.01; 02-28-13

Recruitment Date (RCTLEDDT):
Recruitment Location (RCTLOC):

Recruitment start time (24-hours):(RCSTRTTM)
Recruitment end time (24-hours):(RCENDTM)
Daily census of HIV-positive patients:(RCHIVDC)
Total new admissions:(RCNEWADM)

(hh:mm)

(hh:mm)

(xxx)

(xx)

Screening Status	Reason Patient Declined	Comments
1. (RCSTSR1) <div></div>	(RCDECR1) <div></div>	(RCCOMR1) <div></div>
2. (RCSTSR2) <div></div>	(RCDECR2) <div></div>	(RCCOMR2) <div></div>
3. (RCSTSR3) <div></div>	(RCDECR3) <div></div>	(RCCOMR3) <div></div>
4. (RCSTSR4) <div></div>	(RCDECR4) <div></div>	(RCCOMR4) <div></div>

5. (RCSTSR5)

(RCDECR5)

(RCCOMR5)

6. (RCSTSR6)

(RCDECR6)

(RCCOMR6)

7. (RCSTSR7)

(RCDECR7)

(RCCOMR7)

8. (RCSTSR8)

(RCDECR8)

(RCCOMR8)

9. (RCSTSR9)

(RCDECR9)

(RCCOMR9)

10. (RCSTSR10)

(RCDECR10)

(RCCOMR10)

11. (RCSTSR11)

(RCDECR11)

(RCCOMR11)

<div>O1Z-SCREENED O1a-- Randomized O1b-- Screen failed O1c-- Postponed/rescheduled Z O2-NOT SCREENED *Additional Options Listed Below</div>		
<div>12. (RCSTSR12)</div> <div></div>	<div>(RCDECR12)</div> <div></div>	<div>(RCCOMR12)</div> <div></div>
<div>13. (RCSTSR13)</div> <div></div>	<div>(RCDECR13)</div> <div></div>	<div>(RCCOMR13)</div> <div></div>
<div>14. (RCSTSR14)</div> <div></div>	<div>(RCDECR14)</div> <div></div>	<div>(RCCOMR14)</div> <div></div>
<div>15. (RCSTSR15)</div> <div></div>	<div>(RCDECR15)</div> <div></div>	<div>(RCCOMR15)</div> <div></div>
<div>16. (RCSTSR16)</div> <div></div>	<div>(RCDECR16)</div> <div></div>	<div>(RCCOMR16)</div> <div></div>
<div>17. (RCSTSR17)</div>	<div>(RCDECR17)</div>	<div>(RCCOMR17)</div> <div></div>

01Z-SCREENED 01a-- Randomized 01b-- Screen failed 01c-- Postponed/rescheduled Z 02-NOT SCREENED *Additional Options Listed Below		
18. (RCSTSR18)	(RCDECR18)	(RCCOMR18)
19. (RCSTSR19)	(RCDECR19)	(RCCOMR19)
20. (RCSTSR20)	(RCDECR20)	(RCCOMR20)

Screening Status	Reason Patient Declined	Comments
21. (RCSTSR1)	(RCDECR1)	(RCCOMR1)
22. (RCSTSR2)	(RCDECR2)	(RCCOMR2)
23. (RCSTSR3)	(RCDECR3)	(RCCOMR3)

Z01-SCREENED
01a-- Randomized
01b-- Screen failed
01c-- Postponed/rescheduled
Z02-NOT SCREENED
*Additional Options Listed Below

24. (RCSTSR4)

(RCDECR4)

(RCCOMR4)

25. (RCSTSR5)

(RCDECR5)

(RCCOMR5)

26. (RCSTSR6)

(RCDECR6)

(RCCOMR6)

27. (RCSTSR7)

(RCDECR7)

(RCCOMR7)

28. (RCSTSR8)

(RCDECR8)

(RCCOMR8)

29. (RCSTSR9)

(RCDECR9)

(RCCOMR9)

Z01-SCREENED
01a-- Randomized
01b-- Screen failed
01c-- Postponed/rescheduled
Z02-NOT SCREENED
*Additional Options Listed Below

30. (RCSTSR10)

(RCDECR10)

(RCCOMR10)

31. (RCSTSR11)

(RCDECR11)

(RCCOMR11)

32. (RCSTSR12)

(RCDECR12)

(RCCOMR12)

33. (RCSTSR13)

(RCDECR13)

(RCCOMR13)

34. (RCSTSR14)

(RCDECR14)

(RCCOMR14)

35. (RCSTSR15)

(RCDECR15)

(RCCOMR15)

Z01-SCREENED
01a-- Randomized
01b-- Screen failed
01c-- Postponed/rescheduled
Z02-NOT SCREENED
*Additional Options Listed Below

36. (RCSTSR16)

(RCDECR16)

(RCCOMR16)

37. (RCSTSR17)

(RCDECR17)

(RCCOMR17)

38. (RCSTSR18)

(RCDECR18)

(RCCOMR18)

39. (RCSTSR19)

(RCDECR19)

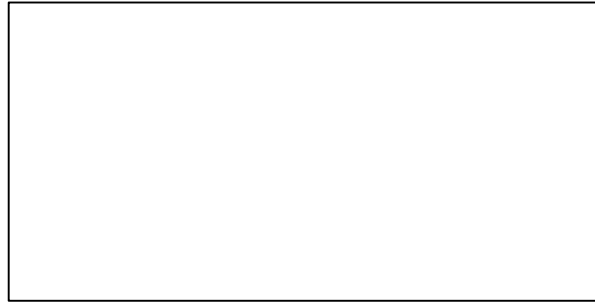
(RCCOMR19)

40. (RCSTSR20)

(RCDECR20)

(RCCOMR20)

Comments: (RCTCOMM)



Additional Selection Options for RCT

Row 1 status
05Z-- PATIENT IS A PRISONER
06Z- CANNOT COMMUNICATE IN ENGLISH
Z03- NO MEDICAL TEAM CLEARANCE
03a-- Not medically stable
03b-- Not interested
03c-- Not available
Z04- PATIENT DECLINED
04a-- Not previously approached
04b-- Previously approached and NOT enrolled
04c-- Already enrolled
04d-- Unknown
07Z-- NO CONTACT MADE

Row 1 reason declined
5- Discharged/left AMA
99- Other, specify in comments

Row 1 status
08-- Pre-screened in eligible
05-- Patient is a prisoner
06-- Cannot communicate in english
Z03- NO MEDICAL TEAM CLEARANCE
03a-- Not medically stable
03b-- Not interested
03c-- Not available
Z04- PATIENT DECLINED
Z05- QUESTION 1: Have study staff approached patient about this study before?
04a-- Not previously approached
04e-- Previously approached and NOT screened
04f-- Previously approached and screen failed
04g-- Previously approached postponed/rescheduled
04h-- Already randomized
04d-- Unknown
07-- No contact made

NIDA Clinical Trials Network

SUD - Cost Information (SCI)

Web Version: 1.0; 3.00; 04-14-14

Segment (*PROTSEG*):
Visit Number (*VISNO*):
SUD Module (*SUD_MOD*):

The next questions will ask about costs/expenses associated with your most recent visit at the _____ facility that we just discussed.

Cost Information for Most Recent Outpatient or Community Clinic

Fill Out only for most recent outpatient or community clinic visit that was HIV related. If none were HIV related fill out for most recent visit.

Cost Information for Most Recent Doctor's Office Visit

Fill out only for most recent doctor's office appointment that was HIV-related. If no doctor's office visit was HIV-related, fill out for most recent Dr. office visit (for whatever reason).

Cost Information for Residential Substance Use Treatment Visit #1

Fill Out only for Most Recent Residential Substance Use Treatment visit

Cost Information for Outpatient Substance Use Treatment Visit #1

Fill Out only for Most Recent Outpatient Substance Use Treatment visit

1. How long did this session (visit to facility) take? Be sure to include any time you were waiting to be seen, the time it took to get to and from the session and the time for the session itself?

a. Waiting time:(*SCWAITHR*)

(xx) Hour(s) (*SCWAITMN*) (xx) Minute(s)

b. Session time:(*SCSESNHR*)

(xxx) Hour(s) (*SCSESNMN*) (xx) Minute(s)

c. Round-trip travel time:(*SCTRVLHR*)

(xx) Hour(s) (*SCTRVLMN*) (xx) Minute(s)

2. How did you get to this facility? (*SCTRNSTO*)

If "Other", specify: (*SCTRNTSP*)

3. Did you get home the same way? (*SCTRNSSM*)

☐ No ☐ Yes

If "No", how did you get back home? (*SCTRNSHM*)

If "Other", specify: (*SCTRNHSP*)

4. If you "Drove yourself" or were "driven by a friend", how many miles did you drive (round-trip if drove both ways)? (*SCMILE*) (xxx)

5. If you "Drove yourself" or were "driven by a friend", did you have to pay for parking? (*SCPARK*)

☐ No ☐ Yes

If "Yes", what was the amount? (*SCPARKCS*)

(xxx.xx)

6. Did you have to arrange child care to go to this session (visit to facility)? (*SCCHILD*)

☐ No ☐ Yes

If "Yes", what child care arrangements did you make?(SCCHLDTP)

If you "paid a baby sitter or other paid child care", how much did you pay for the child care for the time that you needed for this session (visit to the facility)? (SCCHLDCS)

(xxx.xx)

7. Did you receive any vouchers or reimbursement for travel, parking or child care?(SCVOUCHR)

If "Yes", what was the total value of your vouchers/reimbursements?(SCVCHRVL)

☐ No ☐ Yes

(xxx.xx)

8. Did you take time off from work to attend this session (visit to facility)?(SCWORK)

a. If "Yes", how much time did you take off from paid work to attend this session (visit to facility)? (SCWRKHR)

☐ No ☐ Yes

(xx) Hour(s) (SCWRKMN)

(xx) Minute(s)

b. If "Yes", will you lose pay because of this?(SCWRKPAY)

☐ No ☐ Yes

9. Did you take time off from unpaid child care or other household duties to attend this session (visit to facility)?(SEUNPD)

How much time did you take off from unpaid child care or other household duties to attend this session (visit to facility)?(SCUNPDHR)

☐ No ☐ Yes

(xxx) Hour(s) (SCUNPDMN)

(xx) Minute(s)

Comments:(SCICOMM)

Additional Selection Options for SCI

- SUD Module (*SUD_MOD*) (key field):**
1-Module E. Hospital Clinic/Outpatient Department and Doctors Office
2-Module G. Doctors Office
3-Module I. Residential Treatment for Substance Abuse
4-Question 8b: Outpatient Substance Abuse Treatment

- How did you get to this facility?**
6-Ambulance
9-Other

NIDA Clinical Trials Network

SUD - Module B. Inpatient Hospital (SDB)

Web Version: 1.0; 3.03; 09-08-14

Segment (**PROTSEG**):
Report Type (**REPORT**):
Hospital Visit Date (**SDBIH**):

Was the visit date exact or an approximation: (**SBDTEXAP**)

☐ Exact ☐ Approximation

Now I'm going to ask you to tell me about each of the hospitalizations that you mentioned having over the past 6 months.
Secure an appropriate medical release to facilitate medical record abstraction.

1. Hospital name: (**SBHSPNAM**)

2. How many nights were you in the hospital for this stay? (**SBNIGHT**)

 (xxx)

3. How many nights was the participant in the hospital for this stay? (**SBNIGHT**)

 (xxx)

4. During this hospitalization, did the participant spend any nights in the following types of special units?

a. Intensive care unit (ICU/Coronary care unit (CCU): (**SBSPCICU**)

Nights: (**SBNGTICU**) (xxx)

b. Psychiatric unit: (**SBSPCPSY**)

Nights: (**SBNGTPSY**) (xxx)

c. Drug/alcohol unit: (**SBSPCDRG**)

Nights: (**SBNGTDRG**) (xxx)

5. What were the first three discharge diagnoses for this hospitalization?

a. (**SBDISDX**)

b. (**SBDISDX2**)

c. (**SBDISDX3**)

6. Did the participant sign appropriate release form to collect medical records? (**SBPTSIGN**)

☐ No ☐ Yes

Comments: (SDBCOMM)



Additional Selection Options for SDB

- Report Type (*REPORT*) (key field):**
1- Self-report only
2- Abstracted medical record only
3- Combined self-report/abstracted medical record

NIDA Clinical Trials Network

SUD - Module D. Day Hospital/Partial Hospitalization Program (SDD)

Web Version: 1.0; 2.02; 09-08-14

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Facility Name (*PROGRMNM*):

Report Type (*REPORT*):

Now I'm going to ask you to tell me about each of the Day Hospital/Partial Hospitalization Programs that you mentioned visiting in each hospital/program over the past 6 months.

Secure an appropriate medical record release to facilitate medical record abstraction.

1. How many days did you attend this program during the past 6 months?(*SDDAYS*)

(xxx)

2. How many days did the participant attend this program during the past 6 months?(*SDDAYS*)

(xxx)

3. What type of services did you get in this program?

4. What type of services did the participant get in this program?

No Yes Don't Know Refused

a. Medical care:

(*SDMEDCAR*) ☐ ☐ ☐ ☐

b. Mental health care:

(*SDMNTLHT*) ☐ ☐ ☐ ☐

c. Housing assistance:

(*SDHOUSNG*) ☐ ☐ ☐ ☐

d. Other:(*SDOTHSP*)

(*SDOTHER*) ☐ ☐ ☐ ☐

5. Did the participant sign an appropriate release form to collect medical records?(*SDPTSIGN*)

☐ No ☐ Yes

Comments:(*SDDCOMM*)

Additional Selection Options for SDD

- Report Type (*REPORT*) (key field):**
1-Self-report only
2-Abstracted medical record only
3-Combined self-report/abstracted medical record

NIDA Clinical Trials Network

SUD - Module E. Hospital Clinic/Outpatient Department & Doctor's Office (SDE)

Web Version: 1.0; 5.01; 06-24-14

Segment (*PROTSEG*):
Visit Number (*VISNO*):
Facility Name (*PROGRMNM*):
Report Type (*REPORT*):

Now I'm going to ask you to tell me about each of the Hospital Clinic/Outpatient Departments that you mentioned visiting over the past 6 months.
Secure an appropriate medical release to facilitate medical record abstraction

Date of assessment: (*SDEASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)
☐ Clinical/outpatient department ☐ Doctor's office
 (xx)

1. Was the visit to a "clinic/outpatient" or "doctor's office"? (*SEVSTYPE*)

2. How many times did you visit this hospital clinic or outpatient department during the past 6 months?
(*SEVISIT*)

3. How many times did you visit this facility during the past 6 months?

Month (<i>mmm</i>)	Year (<i>yyyy</i>)	Number of Visits (<i>xx</i>)
(<i>SEM OV1</i>) <input type="text"/>	(<i>SEYRV1</i>) <input type="text"/>	(<i>SENUMV1</i>) <input type="text"/>
(<i>SEM OV2</i>) <input type="text"/>	(<i>SEYRV2</i>) <input type="text"/>	(<i>SENUMV2</i>) <input type="text"/>
(<i>SEM OV3</i>) <input type="text"/>	(<i>SEYRV3</i>) <input type="text"/>	(<i>SENUMV3</i>) <input type="text"/>
(<i>SEM OV4</i>) <input type="text"/>	(<i>SEYRV4</i>) <input type="text"/>	(<i>SENUMV4</i>) <input type="text"/>
(<i>SEM OV5</i>) <input type="text"/>	(<i>SEYRV5</i>) <input type="text"/>	(<i>SENUMV5</i>) <input type="text"/>
(<i>SEM OV6</i>) <input type="text"/>	(<i>SEYRV6</i>) <input type="text"/>	(<i>SENUMV6</i>) <input type="text"/>
(<i>SEM OV7</i>) <input type="text"/>	(<i>SEYRV7</i>) <input type="text"/>	(<i>SENUMV7</i>) <input type="text"/>

4. Date of first visit: (*SEPRGDT*)

(mm/dd/yyyy) [Click here for calendar](#)

5. Date of last (most recent) visit: (*SELASTDT*)

(mm/dd/yyyy) [Click here for calendar](#)

6. If the facility is a hospital, what is the name of the clinic or outpatient department within the hospital?
(*SEDEPT*)

- OR -
(*SEDEPUNK*) ☐ Unknown

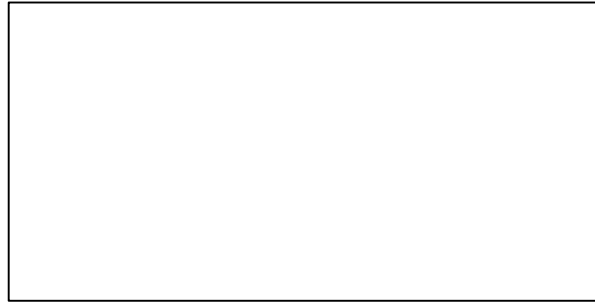
7. If the facility is a "Doctor's office", what is the name of your doctor? (*SEDRNAME*)

- OR - (*SEDRUNK*) ☐ Unknown

8. Did the participant sign an appropriate release form to collect medical records? (*SEPTSIGN*)

☐ No ☐ Yes

Comments: (SDECOMM)



Additional Selection Options for SDE

- Report Type (*REPORT*) (key field):**
1-Self-report only
2-Abstracted medical record only
3-Combined self-report/abstracted medical record

SUD - Module I. Residential Treatment for Substance Abuse (SDI)

Web Version: 1.0; 2.01; 06-25-13

Segment (PROTSEG):
Report Type (REPORT):
Residential Visit Date (SDIRES):

Was the visit date exact or an approximation?(SIDATE) ☐ Exact ☐ Approximation

Now I'm going to ask you to tell me about each of the Residential Treatment visits that you mentioned having over the past 6 months.

- 1. Name of the residential treatment facility or detox hospital:(SITRTNAM)
- 2. How many nights were you in the treatment facility/detox hospital for this stay?(SINIGHTS)
- 3. During this stay, what did you receive treatment for? (SIRCVTRT)

(xxx)

If treated for "Drug abuse", did you receive methadone or Buprenorphine maintenance?
(SIMTHBUP)

Comments:(SDICOMM)

Additional Selection Options for SDI

- Report Type (*REPORT*) (key field):**
1-Self-report only
2-Abstracted medical record only
3-Combined self-report/abstracted medical record

NIDA Clinical Trials Network

SUD - Module A. Emergency Room (SMA)

Web Version: 1.0; 2.01; 06-10-13

Segment (*PROTSEG*):
Visit Number (*VISNO*):
Hospital Name (*SDHSPNM*):
Report Type (*REPORT*):

Now I'm going to ask you to tell me about the ER visits that you mentioned having in each hospital over the past 6 months.
Secure an appropriate medical release to facilitate medical record abstraction.

Date of assessment: (*SMAASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

1. How many ER visits did you have in this hospital in the past 6 months?

Month (<i>mmm</i>)	Year (<i>yyyy</i>)	Number of Visits (<i>xx</i>)
(<i>SAMO V1</i>) <input type="text"/>	(<i>SA YRV1</i>) <input type="text"/>	(<i>SANUMV1</i>) <input type="text"/>
(<i>SAMO V2</i>) <input type="text"/>	(<i>SA YRV2</i>) <input type="text"/>	(<i>SANUMV2</i>) <input type="text"/>
(<i>SAMO V3</i>) <input type="text"/>	(<i>SA YRV3</i>) <input type="text"/>	(<i>SANUMV3</i>) <input type="text"/>
(<i>SAMO V4</i>) <input type="text"/>	(<i>SA YRV4</i>) <input type="text"/>	(<i>SANUMV4</i>) <input type="text"/>
(<i>SAMO V5</i>) <input type="text"/>	(<i>SA YRV5</i>) <input type="text"/>	(<i>SANUMV5</i>) <input type="text"/>
(<i>SAMO V6</i>) <input type="text"/>	(<i>SA YRV6</i>) <input type="text"/>	(<i>SANUMV6</i>) <input type="text"/>
(<i>SAMO V7</i>) <input type="text"/>	(<i>SA YRV7</i>) <input type="text"/>	(<i>SANUMV7</i>) <input type="text"/>

2. Did the participant sign an appropriate release form to collect medical records? (*SAPTSIGN*)

☐ No ☐ Yes

Comments: (*SMACOMM*)

Additional Selection Options for SMA

- Report Type (*REPORT*) (key field):**
1- Self-report only
2- Abstracted medical record only
3- Combined self-report/abstracted medical record

NIDA Clinical Trials Network

SUD - Module C. Nursing Home, Respite Care, Personal Care Home rehabilitation And Hospice Facility (SMC)

Web Version: 1.0; 1.02; 07-01-13

Segment (PROTSEG):

Visit Number (VISNO):

Facility name (SDCNAME):

Report Type (REPORT):

Now I'm going to ask you to tell me about the nursing home, respite care, personal care home rehabilitation and hospice visits that you mentioned having in each facility over the past 6 months.

Date of assessment: (SMCASMDT)

(mm/dd/yyyy) [Click here for calendar](#)

1. What type of facility was this: (SCFACTYP)

2. How many nights were you in the facility for each month in the past 6 months?

Month (mmm):	Year (yyyy):	Number of Nights (xx):
(SCMOV1) <input type="text"/>	(SCYRV1) <input type="text"/>	(SCNUM V1) <input type="text"/>
(SCMOV2) <input type="text"/>	(SCYRV2) <input type="text"/>	(SCNUM V2) <input type="text"/>
(SCMOV3) <input type="text"/>	(SCYRV3) <input type="text"/>	(SCNUM V3) <input type="text"/>
(SCMOV4) <input type="text"/>	(SCYRV4) <input type="text"/>	(SCNUM V4) <input type="text"/>
(SCMOV5) <input type="text"/>	(SCYRV5) <input type="text"/>	(SCNUM V5) <input type="text"/>
(SCMOV6) <input type="text"/>	(SCYRV6) <input type="text"/>	(SCNUM V6) <input type="text"/>
(SCMOV7) <input type="text"/>	(SCYRV7) <input type="text"/>	(SCNUM V7) <input type="text"/>

3. Did the participant sign appropriate release form to collect medical records? (SCPTSIGN)

☐ No ☐ Yes

Comments: (SMCCOMM)

Additional Selection Options for SMC

- Report Type (*REPORT*) (key field):**
1-Self-report only
2-Abstracted medical record only
3-Combined self-report/abstracted medical record

NIDA Clinical Trials Network

Conflictual Social Interaction Scale (STS)

Web Version: 1.0; 1.00; 07-19-12

Segment (*PROTSEG*):

Visit Number (*VISNO*):

Date of assessment: (*STSASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

The next questions are about your interactions with others. During the past four weeks, how much of the time have you (insert question). Would you say none of the time, a little of the time, some of the time, most of the time, or all of the time?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Had serious disagreements with your <u>family</u> about things that were important to you?	(<i>STDISFAM</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Had serious disagreements with your <u>friends</u> about things that were important to you?	(<i>STDISFR</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Felt that others were trying to make changes in you that you did not want to make?	(<i>STCHANGE</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

People sometimes look to others for companionship, assistance, or other types of support. How often was each of the following kinds of support available to you (during the past 4 weeks) if you needed it?

<i>How often do you have:</i>	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Someone to love and make you feel wanted?	(<i>STWANTED</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Someone to help with daily chores (child care, buying food, preparing meals) if you were sick?	(<i>STCHORES</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Someone to help you buy medicines?	(<i>STMED</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Someone to help with transportation?	(<i>STTRAN</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Someone to give you money if you need it?	(<i>STMONEY</i>) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: (*STSCOMM*)

NIDA Clinical Trials Network

Substance Use (SUB)

Web Version: 1.0; 3.00; 04-08-13

Segment (*PROTSEG*):

Visit Number (*VISNO*):

The next several questions are about substance (drug) use.

Date of assessment (*SUBASMDT*)

(mm/dd/yyyy) [Click here for calendar](#)

1. How many times in the past year have you used an illegal drug or used a prescription medication for non medical reasons? (*SUTIMES*)

(xxxx)

Were any of the following used for non-medical purposes?

a. Ecstasy (also known as E, X, or MDMA) (*SUECSTAS*)

☐ No ☐ Yes

b. GHB (also known as gamma hydroxybuturic acid, G, or GBL) (*SUGHB*)

☐ No ☐ Yes

c. Heroin (*SUHEROIN*)

☐ No ☐ Yes

d. Marijuana (*SUMARIJU*)

☐ No ☐ Yes

e. Medical marijuana (*SUMEDMAJ*)

☐ No ☐ Yes

Do you have a prescription for medical marijuana? (*SUMMRX*)

☐ No ☐ Yes

f. Methamphetamine (also known as Crystal Meth, Speed, or Tina) (*SUMETHA*)

☐ No ☐ Yes

g. Hallucinogens (such as LSD, mushrooms, Peyote, or Mescaline) (*SUHALLU*)

☐ No ☐ Yes

h. PCP (also known as Angel Dust, wet, or wicky sticks) (*SUPCP*)

☐ No ☐ Yes

i. Poppers (also known as Amyl Nitrate) (*SUOPPPER*)

☐ No ☐ Yes

j. Powdered Cocaine (*SUCOCAIN*)

☐ No ☐ Yes

k. Rock or Crack Cocaine (*SUROCKCO*)

☐ No ☐ Yes

l. Ketamine (also known as Special K, or K) (*SUKETAMI*)

☐ No ☐ Yes

m. Recreational use of prescription drugs or pain killers to get high (such as Codeine, Vicodin or Hydrocodone, Percocet, Darvon, Oxycontin or Oxycodone, Demerol, or Dilaudid) (*SURECDRU*)

☐ No ☐ Yes

n. Tranquilizers or Barbiturates (such as Valium, Librium, Seconal, Xanax, Ambien, Lorazepam, or Rohypnol--also known as Roofies) (*SUTRANQU*)

☐ No ☐ Yes

2. Does the hospital system medical record have evidence of illegal use of opioids or stimulants or prescription medication abuse in the past 12 months? (*SUDRGHR*)

☐ No ☐ Yes

a. If "Yes", specify:

First drug: (*SUDRUG1*)

Second drug:(SUDRUG2)

T hird drug:(SUDRUG3)

Fourth drug:(SUDRUG4)

Fifth drug:(SUDRUG5)

Sixth drug:(SUDRUG6)

b. If "Yes", specify source of evidence:

	No	Yes
Clinician notes about stimulant use:	(SUSOSTIM) <input type="checkbox"/>	<input type="checkbox"/>
Clinician notes about non-prescribed opioid use:	(SUSONRXO) <input type="checkbox"/>	<input type="checkbox"/>
Clinician notes about prescribed opiate abuse:	(SUSORXOP) <input type="checkbox"/>	<input type="checkbox"/>
Toxicology report for stimulants:	(SUSOTOXR) <input type="checkbox"/>	<input type="checkbox"/>

c. If Toxicology report for stimulants is "Yes", date report obtained:(SUTOXRDT)

(mm/dd/yyyy) [Click here for calendar](#)

Comments: (SUBCOMM)

A large, empty rectangular box with a thin black border, likely intended for a signature or additional comments.

Additional Selection Options for SUB

First drug:
6-Recreational use of prescription drugs or pain killers to get high

NIDA Clinical Trials Network

Service Utilization Detail (SUD)

Web Version: 1.0; 3.04; 08-07-14

Segment (**PROTSEG**):

Visit Number (**VISNO**):

The next questions ask about your use of medical and social services in the past 6 months.

RA Instruction: Provide participant with a reference card that lists all response options for his/her easy reference.

Date of assessment: (SUDASMDT)

(mm/dd/yyyy) [Click here for calendar](#)

1. During the past 6 months, did you go to a hospital emergency room for emergency care?

Include any visits to the emergency room, even if you were admitted to the hospital from there. Include emergency rooms of psychiatric hospitals. Please include your current hospital stay when responding to this question. (SUER)

a. If "Yes," how many different times did you go to a hospital emergency room for emergency care during the past 6 months, including psychiatric hospitals? (SUERVVS)

(xxx) visits

b. During the past 6 months how many emergency departments have you attended? (SUERDEPT)

(xx) departments

2. During the past 6 months, were you a patient in any hospital overnight or longer?

Include psychiatric hospitals. Please include your current hospital stay when responding to this question. (SUOVHS)

a. If "Yes," how many separate overnight hospital stays did you have during the past 6 months, including psychiatric hospital stays? (SUOVHVS)

(xxx) stays

3. During the past 6 months, did you spend one or more nights in a respite care facility, personal care home, nursing home, rehabilitation center, or hospice facility? (SUCARE)

a. If "Yes," how many separate stays in a nursing home or hospice facility did you have during the past 6 months? (SUCAREVS)

(xxx) stays

4. During the past 6 months, did you attend any medical program where you spent the day there but went home at night? *Include day hospitals, partial hospitalizations, or intensive outpatient programs for reasons other than substance abuse. (SUDAYH)*

a. If "Yes," how many different programs like this did you go to during the past 6 months? (SUDAYHVS)

(xx) programs

5. During the past 6 months, did you go to any hospital clinic, hospital outpatient department, community clinic or neighborhood health center for medical care, for example, to care for your HIV/AIDS or other physical problems?
Include visits for urgent care. (SUOUTP)

- a. If "Yes," how many different hospital clinics, outpatient departments, community clinics or neighborhood health centers did you visit for medical care during the past 6 months?(SUOUTPVS)
- b. If "Yes," were any of these HIV primary care visits?(SUPRMCRE)

(xx) clinics, departments, and/or centers

1. What was the date of the first HIV primary care visit to one of these clinics in the last 6 months?
(SUOUT1DT)

(mm/dd/yyyy) [Click here for calendar](#)

2. What was the date of the last HIV primary care visit to one of these clinics in the last 6 months?
(SUOUT2DT)

(mm/dd/yyyy) [Click here for calendar](#)

6. During the past 6 months, did you get medical care in any private doctor's office?(SUDR)

a. If "Yes," how many different private doctor's offices did you visit for medical care during the past 6 months?(SUDRVS)

(xx) different doctor's offices

1. What was the date of the first HIV-related visit to one of these doctor's offices in the last 6 months?
(SUDR1DT)

(mm/dd/yyyy) [Click here for calendar](#)

2. What was the date of the last HIV-related visit to one of these doctor's offices in the last 6 months?
(SUDR2DT)

(mm/dd/yyyy) [Click here for calendar](#)

7. During the past 6 months, did you see any professional for the primary purpose of getting help for a psychological or emotional issue?

These professionals could include psychologist, therapist, counselor, psychiatrist or other doctor. Include groups led by a professional counselor and visits to professionals to get medication for psychological and emotional issues.

Do not include unpaid professionals, such as clergy or other religious/spiritual advisors or healers. (SUPSYC)

Thinking about all the mental health care providers you visited in the past 6 months:

a. How many times did you visit any of these providers to talk about psychological or emotional issues?(SUPSYEM)

(xxx) times

b. In addition to these one-on-one counseling sessions, how many times did you visit any of these providers to discuss your use of prescribed medications for psychological and emotional issues?
(SUPSYMED)

(xxx) times

8. During the past 6 months, did you see any professional for the primary purpose of getting alcohol or drug treatment, including methadone maintenance, or getting help for an alcohol or drug problem? ☐ No ☐ Yes

Include stays in detox hospitals and residential treatment programs as well as groups led by a professional counselor.

Do not include unpaid professionals, such as clergy or other religious/spiritual advisors or healers. (SUDRUG)

a. If "Yes," were you in a residential drug or alcohol treatment facility or detox hospital in which you stayed overnight during the past 6 months? (SUDRUGOV)

1. How many separate stays did you have? (SUDRUGVS)

(xxx) stays

Answer the following questions for the past 6 months and for any outpatient substance abuse treatment that you have received.

- b. How many different alcohol or drug treatment providers in an outpatient setting did you visit during the past 6 months? (SUDRGOPT) (xx) different providers
1. How many days did you attend intensive outpatient substance abuse treatment in the past 6 months? (SUINTOPT) (xxx) days
2. How many days did you attend regular outpatient substance abuse treatment in the past 6 months? (SUREGOPT) (xxx) days

Answer the following questions for the past 6 months for all outpatient substance abuse service providers that you met with.

- c. How many times did you meet one-on-one with an outpatient substance abuse service provider to discuss substance use issues in the past 6 months? (SUDGIND) (xxx) times
- d. How many times did you meet in group sessions with an outpatient substance abuse service provider to discuss substance use issues in the past 6 months? (SUGRPSES) (xxx) times

Answer the following questions for the past 6 months for all substance abuse providers or medical providers.

- e. Are you taking any of the following medications for opioid treatments?

1. Methadone: (SUOUTMET) ☐ No ☐ Yes Methadone treatment center: (SUMETHTX)
2. Buprenorphine (Suboxone): (SUOUTSBX) ☐ No ☐ Yes
3. Naltrexone oral: (SUOUTONX) ☐ No ☐ Yes
4. Naltrexone depot (intramuscular): (SUOUTINJ) ☐ No ☐ Yes

- f. How many times did you pick up opioid replacement medications in the past 6 months? (SUOUTOPI) (xxx) times

9. During the past 6 months, did you participate in any other support group, group counseling or self-help group for emotional, substance abuse or health issues?

This would include groups led by an unpaid professional, for example clergy, or other providers. (SUGR)

- a. If "Yes," how many group sessions did you attend with one of these providers to discuss substance use issues? (SUGRVS) (xxx) group sessions

- b. Which best describes the group you attend or attended?

1. Mental health self-help or support group: (SUGRMN) ☐ No ☐ Yes
How many times did you attend? (SUGRMNTM) (xxx) times
2. Substance abuse self-help or support group: (SUGRSB) ☐ No ☐ Yes
How many times did you attend? (SUGRSBTM) (xxx) times
3. HIV/AIDS self-help or support group: (SUGRHI) ☐ No ☐ Yes
How many times did you attend? (SUGRHITM) (xxx) times
4. Other self-help or support group: (SUGROT) ☐ No ☐ Yes
If "Other," specify (SUGROTSP)
- How many times did you attend? (SUGROTTM) (xxx) times

- OR -

Refused: (SUGRRF) ☐

Don't know: (SUGRDK) ☐

10. During the past 6 months, did you get any dental care? (SUDENTAL)

11. During the past 6 months, did you receive any help at home from professional health care providers, such as nurses, aides or therapists sent by a home health agency, or from other home-based services, such as Meals on Wheels? (SUHOME)

- a. If "Yes," how many different professional home health care providers assisted you during the past 6 months?(SUHOMEPV)
- b. If "Yes," how many different home visits occurred during the past 6 months?(SUHOMEVS)

(xx) providers

(xxx) home visits

c. What kind of home care professionals have visited you?
Let respondent give open-ended answer and mark appropriate response category. Read categories only if respondent cannot answer question.

1. Visiting nurse:(SUNURSE)
2. Home health aide:(SUHMAID)
3. Homemaker:(SUHMMKR)
4. Physical, occupational or respiratory therapist:(SUTHRPST)
5. Counselor or social worker:(SUSOCIAL)
6. Babysitter:(SUBABYST)
7. Meals on wheels worker:(SUMEALS)
8. Other:(SUHOMEOT)

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

If "Other," specify:(SUHOMESP)

12. During the past 6 months, did you receive any help because of a health problem or other disability from family members, friends, or neighbors?

This help could be for medical problems, taking care of yourself, housekeeping, shopping, or any other assistance you might need, including transportation.(SUFAMILY)

13. During the past 6 months, did you spend one or more nights in a homeless or emergency shelter? (SUSHTR)

- a. If "Yes," how many nights did you spend in a homeless or emergency shelter during the past 6 months?(SUSHTRVS)

(xxx) nights

14. During the past 6 months, did you receive any help from case managers or social service workers with things like obtaining health care or legal services, housing, or easing money problems?(SUCASE)

- a. How many different people have been your case manager, or caseworker in the last 6 months? (SUCASENM)
- b. How many times did you have face-to-face meetings with one of your case managers over the past 6 months?(SUCASEVS)

(xx) people

(xxx) times

c. How often did you talk to one of your case managers on the telephone over the past 6 months?
(SUCASEPH)

15. During the past 6 months, did you receive any health care from providers or social service agencies we have not yet discussed?(SUCAREOT)

a. If "Yes," specify each additional provider and/or social service agencies from which you have received health care:

1. (SUCAREO1)
2. (SUCAREO2)
3. (SUCAREO3)
4. (SUCAREO4)
5. (SUCAREO5)

Save this form.
Perform assessments on all required modules before completing the remainder of this form.

Interview Confidence Rating

1. Confidence in assessment:(SUCONFID)

2. Explain here if validity of assessment is questionable.

- a. Participant appeared under the influence:(SUINFLUN)
- b. Participant was uncooperative:(SUCOOPER)
- c. Participant appeared to be lying:(SULYING)
- d. Participant had poor mental recall:(SUMENTAL)
- e. Participant had difficulty understanding questions (other than language barriers):(SUUNDER)
- f. Participant had difficulty understanding questions (due to language barriers):(SULANGAG)

- ☐ No

☐ Yes
- ☐ No

☐ Yes
- ☐ No

☐ Yes
- ☐ No

☐ Yes
- ☐ No

☐ Yes
- ☐ No

☐ Yes

Comments:(*SUDCOMM*)

Additional Selection Options for SUD

How often did you talk to one of your case managers on the telephone over the past 6 months?

97 -Don't know

98 -Refused