

Form Approved
OMB No. 0920-1100
Expiration Date: XX/XX/XXXX

**Identification of behavioral and clinical predictors of early
HIV infection
(Project DETECT)**

Attachment 11b

Phase 2 HIV Symptom and Care Survey (Spanish)

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-1100)

Project DETECT: Part 3 Questionnaire #1

Description: Computer-assisted interview for study staff to complete with participants in Part 3 at each follow-up visit. Study staff will complete a set of 'Face page' questions, the participant will be asked about providing consent and, for those who provide consent, the study staff will ask them the remainder of the survey questions and enter their answers into the computer.

FACE PAGE

Note to study RA: Input the dates and study ID number(s).

FP-1 Research assistant ID: _____

FP-2 UW Study ID for part 2: _____

FP-3 UW Study ID for part 3: _____

FP-4 CSID: _____

FP-5 Visit Date: MM/DD/YYYY

Note for study staff: If this is the participant's first Part 3 visit (Visit #1) the previous visit date should be the participant's Part 2 visit date.

FP-6 Previous Visit Date: MM/DD/YYYY

FP-7 Visit number: _____

Formulario aprobado

OMB Nro. 0920-1100

Fecha de vencimiento: XX/XX/XXXX

La carga de informes públicos de esta recopilación de información se estima en un promedio de 5 minutos por respuesta, lo que incluye el tiempo para revisar instrucciones, buscar fuentes de datos existentes, recopilar y mantener los datos necesarios y completar y revisar la recopilación de información. Una agencia no podrá ser conductor ni patrocinador, y una persona no está obligada a responder una recopilación de información, a menos que muestre un número de control OMB actualmente válido. Envíe sus comentarios con respecto a esta estimación de la carga o a cualquier otro aspecto de esta recopilación de información, lo que incluye sugerencias para reducir esta carga, al CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-1100).

CONSENT

[Show section if FP-7 = 1.]

Ya hemos discutido las siguientes preguntas con usted, pero nos gustaría documentar sus respuestas electrónicamente. Si tiene alguna pregunta sobre lo que estamos indagando, hable con el personal del estudio antes de responder.

CT-1 ¿Está de acuerdo en participar en el estudio?

- Sí
- No

CT-2 Le solicitamos que acepte congelar parte de sus muestras de sangre y fluido oral en el CDC para su uso futuro. Podríamos usar estas muestras para investigación en el futuro. No se mantendrá nada que pueda relacionarlo a usted con sus muestras de sangre o fluidos orales. No estamos seguros de qué estudios se podrían hacer en el futuro. Pueden incluir pruebas estándar como las realizadas en hospitales, pruebas de VIH u otros virus o de su sistema inmunológico (capacidad para combatir infecciones). No realizaremos pruebas para detectar problemas genéticos ni utilizaremos muestras de sangre o fluidos orales para clonación o fines comerciales.

Doy mi consentimiento para que mis muestras de sangre y fluidos orales se almacenen en CDC para su uso futuro como se describió anteriormente.

NO DOY mi consentimiento para que mis muestras de sangre y fluidos orales se almacenen en CDC para investigaciones futuras.

If CT-1 or CT-2 = “No,” participant has declined participation in the study. Screen will say, “Haga una pausa aquí en la encuesta y hable con el personal del estudio.” Study staff will discuss the response with the participant and address any questions or concerns. If participant does not want to participate, study staff will end the survey and withdraw participant from the study. If participant does want to participate and responded inaccurately for any reason, study staff will help the participant navigate back to the question and answer it correctly, so the participant can proceed with the remainder of the survey.

The survey will start once you click the “Next question” button.

PRIOR STUDY PARTICIPATION

[Show section if FP-7 = 1.]

PS-1. Have you previously participated in an HIV vaccine trial?

- Yes
- No
- I don't know

[If PS-1 = “Yes”] PS-2. Which did you receive as part of your study participation?

- A vaccine
- A placebo

I don't know/I never learned which one I received

SYMPTOMS

SY-1 Since your last visit on [*insert date*], have you had any of these symptoms? Check all that apply.

- a. Sore throat
- b. Fever
- c. Nausea
- d. Vomiting
- e. Diarrhea
- f. Headache(s)
- g. Fatigue
- h. Soreness or pain in your joints or muscles
- i. Swollen lymph nodes
- j. Body Rash
- k. I haven't experienced any of these symptoms since my last visit

For any checked symptoms:

SY-2a-SY-2j You said that you have had [*insert symptom*] since your last visit on [*insert last visit date*]. Do you have [*insert symptom*] today?

Yes

No

SY-3a-SY-3j When did you first experience this symptom [*insert symptom*]?

MM/DD/YYYY

[*If SY-2a-SY-2j = No:*] SY-4a-SY-4j When did you last experience this symptom [*insert symptom*]?

MM/DD/YYYY

If reported any symptoms:

SY-5 Did you go to a doctor or health care provider because of your symptom(s)?

Yes

No

SY-6 Did you miss work or school because of your symptom(s)?

Yes

No

SY-7 Were you hospitalized because of your symptom(s)?

Yes

No

HIV CARE

HC-1 Do you currently have a doctor or medical provider for HIV care?

Yes

No

HC-2 Since your last visit on [*insert date*], have you been to a doctor or medical provider for HIV care?

Yes

No

[*If HC-2 = "Yes"*] HC-3 When did you last see your HIV doctor or medical provider?

MM/DD/YYYY

HC-4 Are you currently taking medicines to treat your HIV?

Yes

No

[*If HC-4 = No:*] HC-5 Have you taken medicines to treat your HIV since your last visit on [*insert date*]?

Yes

No

[*If HC-4 = Yes OR HC-5 = Yes:*] HC-6 When did you start taking medicines to treat your HIV?

MM/DD/YYYY

[*If HC-4 = No AND HC-5 = Yes:*] HC-7 When did you stop taking medicines to treat your HIV?

MM/DD/YYYY

This is the end of the survey.