Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

CHEST X-RAY SCREENING EXAMINATION (XRY2)

DO NOT FOLD, STAPLE, OR TEAR THIS FORM. USE A NO. 2 PENCIL TO COMPLETE THIS FORM.

1. Date of Examination: ___________________________________________  
   Month             Day             Year

2. Satellite Center: ___ ___

3. Study Year:  
   ○ T₀  
   ○ T₁  
   ○ T₂  
   ○ T₃

4. Visit Number:  
   ○ One  
   ○ Two  
   ○ Three

5. Reason for Repeat Visit:
   ____________________________  
   ____________________________  
   ____________________________  
   ____________________________  
   ____________________________

FOR OFFICE USE ONLY

6. Forms Processing (MARK RESPONSES AS STEPS ARE COMPLETED)  
   ○ Form Receipted into SMS  
   ○ Manual Review Completed

Data Entry of Non-Scannable Items:  
   ○ Completed OR  
   ○ None Required
**Data Retrieval:**
○ Attempted OR
○ None Required

**Disposition:**
○ Final Complete (FCM) OR
○ Final Incomplete (FIC)

Public reporting burden for this collection of information is estimated to average 10 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: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0407). Do not return the completed form to this address.

Version Date: 10/99   Expiration Date: 10/02       Form Approved OMB No.: 0925-0407

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**PART A: CHEST X-RAY EXAMINATION FINDINGS (COMPLETED BY TECHNOLOGIST)**

1. **Number of Attempts:**
   ○ None (GO TO 2)
   ○ One
   ○ Two

2. **Adequate Films Obtained:**
   ○ No
   ○ Yes (GO TO 4)

3. **Reason for Inadequate Films: (MARK ALL THAT APPLY)**
   ○ Participant Refusal
   ○ Equipment Malfunction
   ○ Poor Film Quality
   ○ Other (SPECIFY) ______________________________

4. **COMMENTS:**
   ○ No
   ○ Yes (SPECIFY)

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○ (CONTINUED)
5. Tech. ID: _____ _____ _____
   Signature: ______________________

   PART B: CHEST X-RAY EXAMINATION FINDINGS (COMPLETED BY RADIOLOGIST)

   1. Radiographic Abnormality Noted:
      ○ No (GO TO PART C)
      ○ Yes

   2. Record Information for Each Abnormality:

<table>
<thead>
<tr>
<th>Abnormality #</th>
<th>LOCATION (MARK ALL THAT APPLY)</th>
<th>DESCRIPTION OF ABNORMALITY</th>
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<tbody>
<tr>
<td></td>
<td>Right Hemithorax</td>
<td>Left Hemithorax</td>
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<tr>
<td>1 = Upper 1/3</td>
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<td>1 = Upper 1/3</td>
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<td>2 = Middle 1/3</td>
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<td>2 = Middle 1/3</td>
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<td>3 = Lower 1/3</td>
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<td>4 = Diffuse</td>
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<td>4 = Diffuse</td>
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   2. 
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   4. 
   5. 

   PART C: CHEST X-RAY INTERPRETATION RESULTS (COMPLETED BY RADIOLOGIST)

   1. Examination Result:
      ○ Positive Screen – Referral Required (GO TO 3)
      ○ Negative Screen – No Abnormalities (GO TO 3)
      ○ Negative Screen – Other Abnormalities (GO TO 3)
      ○ Inadequate
2. Reason for Inadequate Exam: (MARK ALL THAT APPLY)
   ○ Poor film quality
   ○ Films lost
   ○ Other (SPECIFY)

   _________________________________
   _________________________________
   _________________________________
   _________________________________

3. Level of Referral:
   ○ 1 – Significant Abnormality, Referral
   ○ 2 – Moderate Abnormality, Referral
   ○ 3 – Slight Variation from Normal, No Referral
   ○ 4 – Normal/Result Not Available, No Referral

4. COMMENTS:
   ○ No
   ○ Yes (SPECIFY)

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5. Radiologist ID: ____ ____ ____ ____

   Signature: ______________________