

Participant ID Number

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 Received 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

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)

Item #	Comments

(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:

Abnormality #	LOCATION (MARK ALL THAT APPLY)		DESCRIPTION OF ABNORMALITY
	Right Hemithorax	Left Hemithorax	
	1 = Upper 1/3 2 = Middle 1/3 3 = Lower 1/3 4 = Diffuse 9 = NA	1 = Upper 1/3 2 = Middle 1/3 3 = Lower 1/3 4 = Diffuse 9 = NA	01 = Nodule (1-30 mm) 02 = Mass (>30 mm) 07 = Pleural mass 08 = Granuloma(s) 13 = Right hilar/mediastinal lymph nodes (exclude calcified nodes) 14 = Left hilar/mediastinal lymph nodes (exclude calcified nodes) 15 = Major atelectasis/collapse 16 = Infiltrate (consolidation/alveolar opacity) 17 = Scarring/pulmonary fibrosis/honeycombing 18 = Pleural fibrosis/pleural plaque 19 = Pleural fluid 20 = Bone/soft tissue lesion 21 = Cardiac abnormality/cardiomegaly/congestive heart failure 22 = COPD/emphysema/bullae 88 = Other (SPECIFY)
1.			
2.			
3.			
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)

Item #	Comments

(CONTINUED)

5. Radiologist ID: _____

Signature: _____