# PULMONARY AIDS CLINICAL STUDY
## FORM B - BRONCHOSCOPY FORM

**Version Date:** The version date of the form, located in the upper right corner of the form, should be checked by the interviewer to insure that the correct version of the form is being used.

1. **Patient ID:** The patient's ID label should be affixed here. If a label is not available, the ID should be printed neatly in the space provided.

2. **Clinic:** Enter the two digit clinic-specific ID number in the boxes provided. For all clinics that are composed of only one primary center, a '01' should be entered. If there is more than one clinic at a particular center, the investigator at the center should assign each clinic a different clinic ID number beginning with '01' and going in sequence. A list of the assigned clinic numbers should then be sent to the Coordinating Center.

3. a. **Date of Procedure:** Enter the date the procedure was performed. Remember to use the complete date format described earlier in this document.
   b. **Procedure Performed By:** The name of the person that performed the procedure should be entered in the space provided.

4. **Types of Procedures Performed:** Check the appropriate box indicating whether the procedure listed was performed or not. If a procedure other than those listed was performed, specify the particular procedure in the space provided in question G. **Each procedure performed should generate a specimen evaluation and thus a specimen evaluation Form V.**

5. **Purpose of Procedures:** Check the appropriate box indicating the purpose of performing the above procedures.

6. **Airway Findings:** Indicate YES or NO, if the airway findings are normal. If YES, skip to question 7. If NO, indicate in questions 6B thru 6F whether any of the listed conditions were found. Print the location and description of the condition where appropriate.

7. **Complications:** Indicate YES or NO, if any complications were encountered while performing the procedures. If YES, indicate in Questions B-D whether the listed complications were encountered. If a complication other than those listed was encountered, specify the complication in Question E.

8. ***Visit Type:*** Indicate the visit type by checking the appropriate box. If **Baseline** or **Scheduled Follow-up** visit, skip to Question 10.

9. ***Qualify as Scheduled Visit:*** Indicate Yes or No if the symptom generated or one month follow-up visit qualifies by protocol definition as a scheduled visit. If the visit does not qualify as a scheduled visit, skip to Question 11.

10. ***Scheduled Follow-up Month:*** If baseline visit, enter 00 in the boxes provided. Otherwise, indicate which scheduled follow-up visit the form is being completed for. For routine patients, these should be the 06, 12, 18, 24, 30, 36, 42 and 48 month visits. For intense patients, these should be the 03, 06, 09, 12, 15, 18, etc. month visits.

11. ***Date of Associated Intake, Interval, or Hospital Form:*** Indicate the date of the Intake, Interval, or Hospital form that was completed at the visit in which this form is also being completed. If no Interval, Intake or Hospital form is associated with this form, the date should be left blank and keyed as a -1 in the Day boxes.

PLEASE COMPLETE <u>ONE</u> SPECIMEN EVALUATION FORM FOR <u>EACH</u> SPECIMEN!!

**Form Reviewer/Date:** The individual, other than the interviewer, that reviews the form for completeness and correctness should print their name and the date the form was reviewed in a legible manner in the space provided.

**Form Keyer/Date:** The individual that keys the form using the RTIDE screen entry package should print their name and the date the form was keyed in a legible manner in the space provided.

FORM B

Version: 01 NOV 89

# PULMONARY COMPLICATIONS OF HIV INFECTION
## BRONCHOSCOPY FORM

1. Patient ID ............................................ [ ][ ][ ][ ][ ]

2. Clinic ................................................ [ ][ ]

| | Day | Month | Year |
|---|---|---|---|
| 3. A. Date of Procedure ........................ | [ ][ ] | [ ][ ][ ] | [ ][ ] |

B. Performed by: ______________________________

4. Types of Procedures Performed:

| | Yes | No |
|---|---|---|
| A. Bronchoalveolar Lavage ........................ | [ ] y | [ ] n |
| B. Protected Brush Specimen ........................ | [ ] y | [ ] n |
| C. Transbronchial Needle Aspirate ........................ | [ ] y | [ ] n |
| D. Transbronchial Bx ........................ | [ ] y | [ ] n |
| E. Endobronchial Bx ........................ | [ ] y | [ ] n |
| F. Cytology Brush ........................ | [ ] y | [ ] n |
| G. Other ........................ | [ ] y | [ ] n |

Specify: ______________________________

5. Purpose of Procedures:

A. Routine .............................. [ ] 01

B. Symptom Workup .............................. [ ] 02

6. Airway Findings:

| | Yes | No |
|---|---|---|
| A. Normal (If YES, go to 7) .................... | ☐ y | ☐ n |
| B. Diffuse tracheobronchitis ............... | ☐ y | ☐ n |
| C. Masses ................................ | ☐ y | ☐ n |
| Specify location: ____________ | | |
| Description: ____________ | | |
| D. Presumed Airway Candidiasis ............ | ☐ y | ☐ n |
| E. Presumed KS Lesions .................... | ☐ y | ☐ n |
| F. Other .................................. | ☐ y | ☐ n |
| Specify location: ____________ | | |
| Description: ____________ | | |

7. Complications:

| | Yes | No |
|---|---|---|
| A. Complications (If NO, go to END) ........................ (If YES, what kind?) | ☐ y | ☐ n |
| B. Pneumothorax .................................... | ☐ y | ☐ n |
| If YES, was a chest tube required? .................. | ☐ y | ☐ n |
| C. Bleeding (estimate greater than 50cc) .............. | ☐ y | ☐ n |
| D. Bronchospasm .................................... | ☐ y | ☐ n |
| E. Other (specify) ____________... | ☐ y | ☐ n |

FORM B

Version: | 0 | 1 | | N | O | V | | 8 | 9 |

PLEASE COMPLETE ONE SPECIMEN EVALUATION FORM FOR EACH SPECIMEN

8. Visit Type: ☐$_0$ Baseline* ☐$_1$ Scheduled Follow-up* ☐$_2$ Symptom Generated

☐$_3$ One Month Follow-up ☐$_4$ Hospital

*** If Baseline or Scheduled Follow-up, skip to 10.**

| | Yes | No |
|---|---|---|
| 9. Does this visit qualify as a scheduled visit? ............ | ☐ y | ☐ n |

**If No, skip to 11.**

10. For which scheduled follow-up visit does this qualify? .... ☐☐ month
(00=Baseline; 03 month, 06 month, 09 month, etc.)

11. Date of Intake, Interval, or Hospital Form associated with this form:

| Day | Month | Year |
|---|---|---|
| ☐☐ | ☐☐☐ | ☐☐ |

Form Reviewed By: ______________________ Date ____________
(please print)

Form Keyed By: ______________________ Date: ____________
(please print)