ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
PULMONARY FUNCTION SURVEY

Form Completion Instructions:

This form should be completed by each Clinical Center identifying the policies and procedures followed in each Center's Pulmonary Function Laboratory. This form should be completed whenever a policy or procedure changes.

ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
Pulmonary Function Survey

This form should be completed by each Clinical Center indicating their pulmonary laboratory's policies and/or procedures on the use of bronchodilators. The form should be completed whenever a policy or procedure changes.

1. Date form completed:..... ___ /

2. Clinical Center code number:

3. Wil...

...scribed in our Pulmonary ...logy (specify name): _____ ___(1)Yes ___(2)No ___(9)Unknown

b. Use bronchodilator prescribed by physician only..... ___(1)Yes ___(2)No ___(9)Unknown

c. Other (specify): _____ ___(1)Yes ___(2)No ___(9)Unknown

4. How will this bronchodilator be administered on Registry patients?

a. Aerosol only (skip to item 7 if YES) ..... ___(1)Yes ___(2)No ___(9)Unknown

b. Metered Dose Inhaler (MDI) only ..... ___(1)Yes ___(2)No ___(9)Unknown

c. MDI with spacing device (specify type): _____ ___(1)Yes ___(2)No ___(9)Unknown

d. Other (specify): _____ ___(1)Yes ___(2)No ___(9)Unknown

5. What is the number of metered dose inhalations that will be given to Registry patients? (breaths) ..... ___ ___

6. What is the interval between metered dose inhalations? (minutes)..... ___ ___

7. What is the interval between bronchodilator treatment and post-bronchodilator spirometry? (minutes)..... ___ ___

Please provide any comments you feel will help describe your bronchodilator procedure:

_____

_____

_____

Clinical Center: ___ ___
Date Form Completed: ___ ___/ ___ ___/ ___ ___
month day year

8. Please identify your laboratory's variability limits for repeat measurements for the following parameters:

	%	OR	ml
a. FVC	___ ___ ___		___ ___ ___
b. FEV_1	___ ___ ___		___ ___ ___
c. FRC	___ ___ ___		___ ___ ___
d. DLCO	___ ___ ___		___ ___ ___

9. Indicate the method(s) that will be used on Registry patients for determining lung volumes:

a. Helium dilution ___(1)Yes ___(2)No ___(9)Unknown

b. Nitrogen washout ___(1)Yes ___(2)No ___(9)Unknown

c. Body plethysmography ___(1)Yes ___(2)No ___(9)Unknown

d. X-ray planimetry ___(1)Yes ___(2)No ___(9)Unknown

e. None ___(1)Yes ___(2)No ___(9)Unknown

f. Unknown ___(1)Yes ___(2)No ___(9)Unknown

10. Which of the techniques will be used preferentially on Registry patients? ___
    1 = Helium dilution
    2 = Nitrogen washout
    3 = Body plethysmography
    4 = X-ray planimetry
    5 = Some combination
    9 = Unknown

11. Does your test equipment/testing protocol allow for measurement of lung subdivisions (ERV/IC) before or after measurement of FRC without the patient coming off of the mouthpiece? ___(1)Yes ___(2)No ___(9)Unknown

12. Will you perform a slow vital capacity as part of a routine spirometry on Registry patients? (recommended) ___(1)Yes ___(2)No ___(9)Unknown

13. To what endpoint does your laboratory strive for as "ideal" end-of-test for the forced vital capacity maneuver?

    a. minimum expiratory time (seconds) ___ ___ . ___

    b. volume increment (ml/sec) ___ ___ ___

Clinical Center: ___ ___
Date Form Completed: ___ ___/ ___ ___/ ___ ___
month day year

Describe: _____

_____

_____

14. What is the maximum expiratory time beyond which the technician will terminate the forced expiratory maneuver? (seconds) ..... ___ ___

15. What is the altitude at your laboratory (feet above sea level) ..... ___ ___ ___ ___

16. Does your laboratory routinely apply a correction for abnormally high or low hemoglobin levels on DLCO results? ..... ___(1)Yes ___(2)No ___(9)Unknown

If YES, indicate formula: _____

17. a. Do you run biological controls (normals) on your pulmonary function test equipment? ..... ___(1)Yes ___(2)No ___(9)Unknown

If YES,

b. Indicate frequency as follows: ..... ___

1 = daily
2 = once per week
3 = once per month
4 = once per quarter
5 = on the day of Registry patient visit
6 = other (specify) _____
9 = unknown

18. Please list the names, titles, and credentials of your pulmonary function staff who will be involved in testing Registry patients. Include any employees at your facility who may be involved in the Registry and briefly describe their function.

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Person Completing Form: _____

White/Yellow: Clinical Coordinating Center, Pink: Clinical Center

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