PULMONARY AIDS CLINICAL STUDY
FORM O - OTHER DIAGNOSTIC PROCEDURES

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. **Time of Procedure**: Record military time of procedure or 00:00.

4. **Type of Procedure**: Check the appropriate box indicating the type of procedure performed. If the ***Other*** category is checked, be sure to specify the type of procedure. Only one procedure type should be specified per form.

5. **Location**: Enter the hospital or clinic name where the diagnostic procedure was performed.

6. **Complications**: Indicate whether any complications resulted from the procedure. If No, skip to question 7. If Yes, indicate whether complications listed in Questions B thru G were present. In Question G, be sure to specify the particular complication in the space provided.

7. a. **Pleural Fluid Results:** Indicate in the boxes provided whether the chemistry tests were completed. If so, record the results being sure to use the specified units of measurement. If something other than that provided is measured, be sure to provide the test name and the value of the test in the space provided. If a particular test is not performed, leave it blank.

   b. **Cell Counts:** Indicate in the boxes provided whether the hematology part of the procedure was completed. If so, complete the hematology measurements being sure to use the specified units of measurement. If something other than that provided is measured, be sure to provide the test name and the value of the test in the space provided. If a particular count is not measured, leave the corresponding boxes blank.

   c. **Cytology:** Indicate if cytology was done and if so, specify the tests and values.

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.*

Form Completed By: Indicate the name of the individual that completed the form.

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 O Version: 1 0 J U N 9 1

PULMONARY COMPLICATIONS OF HIV INFECTION
OTHER DIAGNOSTIC PROCEDURES

1. Patient ID .... ☐☐☐☐☐

2. Clinic .... ☐☐

	Day	Month	Year
3. A. Date of Procedure	☐☐	☐☐☐	☐☐

B. Time (military) .... ☐☐ : ☐☐

4. Procedure Type:

A. Thoracentesis .... ☐ 01

B. Pleural Biopsy .... ☐ 02

C. Thoracotomy/Open Lung Biopsy .... ☐ 03

D. Thoracotomy/Lymph Node Biopsy .... ☐ 04

E. Mediastinoscopy .... ☐ 05

F. Peripheral Lymph Node Biopsy .... ☐ 06

G. Other (specify) ____________________ ☐ 07

5. Location:

If inpatient, hospital name: ______________________________

If outpatient, clinic name: ______________________________

6. Complications:	Yes	No
A. Complications (If NO, go to Question 7)	☐ y	☐ n
B. Pneumothorax	☐ y	☐ n
If YES, was a chest tube required?	☐ y	☐ n

	Yes	No
C. Bleeding (≤ 300 cc)	$\square_y$	$\square_n$
D. Bleeding (> 300 cc)	$\square_y$	$\square_n$
E. Infection (specify) ____________________	$\square_y$	$\square_n$
F. Death	$\square_y$	$\square_n$
G. Other (specify) ____________________	$\square_y$	$\square_n$

7. Pleural Fluid Results:

A. Chemistry Completed .... $\square_y$ $\square_n$

PH ☐.☐☐ Protein ☐☐.☐ (G/100 ml)

Glucose ☐☐☐☐ (mg/100 ml) LDH ☐☐☐☐ (U/L)

Amylase ☐☐☐ (U/L)

Other Chemistry: Yes $\square_y$ No $\square_n$ ____________________ Specify Test and Value

	Yes	No
B. Cell Counts Completed	$\square_y$	$\square_n$

White Cell Count ☐☐.☐ (x 10^3/mm^3)

Eo (%) ☐☐

PMN (%) ☐☐

Lymph (%) ☐☐

C. Cytology: Yes $\square_y$ No $\square_n$ ____________________ Specify Test and Value

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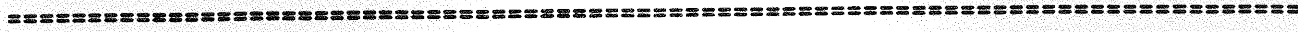
PLEASE COMPLETE ONE SPECIMEN EVALUATION FORM FOR EACH SPECIMEN.



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.**

9. Does this visit qualify as a scheduled visit? .... Yes ☐$_y$ No ☐$_n$

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
☐☐	☐☐☐	☐☐

Procedure Completed By: ______________________________

Form Reviewed By: ______________________ Date______________
(please print)

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