Embedded in the variable name is the number of the outcome event, indicated by n. There are 7 possible outcome forms per ID. ie:F31n3A1=F3113A1.

Clinic No.						
ID No.			X			
Form Type	O	R				

PART I: Identifying Information.

1. Patient's NAME CODE:

   — — — — —

2. Date of outcome event:

   Used to calculate days to event: EVNT1 to EVNT7

   — — - — — - — —
   Month   Day   Year

3. Person(s) completing this form:

   A. Principal Investigator:

      1. Certification Number:

         — — - — —

      2. Signature:

         _____

   B. Other PIOPED Investigator:

      1. Certification Number:

         — — - — —

      2. Signature:

         _____

4. Sources of data for this outcome report (check all that apply):

   A. Patient ------------------------ (1)
   B. Relative ----------------------- (1)
   C. Personal Physician ------------- (1)
   D. PIOPED Clinical Scientist ------ (1)
   E. Medical Office Record ---------- (1)
   F. Hospital Record ---------------- (1)
   G. Lung Scan Report --------------- (1)
   H. Angiogram Report --------------- (1)
   I. Death Certificate -------------- (1)
   J. Autopsy Report ----------------- (1)

   ┌───┐
   │ Record the form type in the appropriate boxes │
   │ in the upper right-hand corner of this page. │
   │ Code as: │
   │   First outcome reported for a patient --- 01 │
   │   Second outcome report for a patient ---- 02 │
   │   Third outcome reported for a patient --- 03 │
   │   etc. │
   └───┘

PART II: Outcomes.

5. Outcomes reported for this patient include:

	Yes	No
A. Death --------------------	(1)	(2) F31n5A
B. Complications of anti-coagulation therapy ------	(1)	(2)

   ┌────────────────────────────┐
   │ If NO, proceed to Item 5C. │
   └────────────────────────────┘

   Anticoagulation therapy complications (check all that apply):

   1. Major bleeding ------------- (1)
   2. Minor bleeding ------------- (1)
   3. Other, specify ------------- (1)

   _____

   _____

	Yes	No
C. Pulmonary embolus --------	(1)	(2) F31n5C
D. Hospitalization ---------	(1)	(2) F31n5D
E. Other, specify -----------	(1)	(2)

   _____

	Yes	No
6. Was there an autopsy? -------	(1)	(2)

   ┌──────────────────────────────┐
   │ If YES, complete an Autopsy │
   │ Form (PIOPED Form 34) as │
   │ soon as possible. │
   │ If NO, proceed to Item 8. │
   └──────────────────────────────┘

7. Did the autopsy find pulmonary emboli present? ------ (1) (2)

8. Were pulmonary angiograms collected during PIOPED follow-up for this patient? - (1) (2)

   ┌──────────────────────────────────────┐
   │ If YES, forward the pulmonary angio- │
   │ gram and a copy of the angiography │
   │ report to the DCC as soon as pos- │
   │ sible. │
   │ If NO, proceed to Item 10. │
   └──────────────────────────────────────┘

9. Did these pulmonary angio-
grams find pulmonary emboli
present? ─────────────── (1) (2)
                          Yes   No

10. Were V̇/Q̇ scans performed
during PIOPED follow-up
for this patient? ─────── (1) (2)
                          Yes   No

```
┌─────────────────────────────────────┐
│ If YES, forward the V̇/Q̇ scans and a  │
│ copy of the scan interpretation to   │
│ the DCC as soon as possible.         │
│ If NO, proceed to Item 12.           │
└─────────────────────────────────────┘
```

11. The V̇/Q̇ scans were read locally as:

Normal ───────────────────── (1)
Low probability ─────────────── (2)
Intermediate probability ─────── (3)
High probability ────────────── (4)

- -

12. Diagnoses:

A.		DIAGNOSES	B.	ICD-9 CODES
(Primary)	1.	_____	1.	__ __ __ __ . __
(Secondary)	2.	_____	2.	__ __ __ __ . __
	3.	_____	3.	__ __ __ __ . __
	4.	_____	4.	__ __ __ __ . __

PART III: Coordination.

Prepare a narrative summary of the outcome(s) reported on this form to accompany this form.
Be sure to include in the narrative summary all information from the patient's history,
physical examination, and laboratory evaluations relevant to the outcome(s) reported. For
all hospitalizations be sure to attach a discharge summary. For all deaths, be sure to
attach a copy of the death certificate. Copies of correspondence from treating physicians
and other relevant documents should also be attached to this form.

13. Checked for completeness and accuracy:

A. Certification Number:

          __ __ - __ __

B. Signature:

    _____

C. Date:

      __ __ - __ __ - __ __
      Month   Day   Year

```
┌─────────────────────────────────────┐
│ Retain a copy of this form for your  │
│ files. Send the original to the      │
│ PIOPED Data and Coordinating Center. │
│ Use PIOPED mailing labels:           │
│                                      │
│    Maryland Medical Research         │
│    Institute                         │
│    PIOPED Data and Coordinating      │
│    Center                            │
│    600 Wyndhurst Avenue              │
│    Baltimore, Maryland   21210       │
└─────────────────────────────────────┘
```

DCC USE ONLY		
Included:	Yes	No
1. Death Certificate ──────	(1)	(2)
2. Discharge Summary ──────	(1)	(2)
3. Narrative ─────────────	(1)	(2)
4. Correspondence ─────────	(1)	(2)
5. Other ────────────────	(1)	(2)

ID No. [| | | | | |]