

Clinic No.						
ID No.						
Form Type	S	F	O	I		

PART I: Identifying Information.

1. Patient's NAME CODE: _____

2. Date roster entry made: _____

This is entry date- All event days are calculated from this date.

Month - Day - Year

PART II: Patient Status.

3. Outer envelope opened? ----- (1) (STOP)
Yes No

If NO, do not complete this form, but return sealed envelope to the DCC.

4. Patient selected for:

Recruitment ----- (1)
No Contact ----- (STOP)

If NO CONTACT, do not complete this form, return unopened mailer to DCC.

5. Mailer opened? ----- (1) (2)
Yes No

If YES, proceed to Item 6.

A. Reason for not opening mailer:

Scan request cancelled ---- (1)
Patient refused ----- (2)
M.D. refused ----- (3)
Ineligible ----- (4)
Other, specify ----- (5)

If SCAN REQUEST CANCELLED, proceed to Part III. If PATIENT REFUSED, M.D. REFUSED or OTHER, proceed to Item 5C.

B. Reason for ineligibility (check all that apply):

1. Pregnancy ----- (1)
2. Contrast allergy ----- (1)
3. Age ----- (1)
4. PE diagnosis untenable- (1)
5. Other, specify ----- (1)

If PE DIAGNOSIS UNTENABLE or OTHER, complete Supplemental Status Form.

5. (Continued)

C. Was permission to characterize obtained?

Yes ----- (1)
No ----- (2)
Not applicable ----- (3)

Proceed to Part III.

6. Group assignment (for eligible patient giving informed consent):

A. Patient assigned to (check one):

PIOPED angiographic pursuit ----- (1)
Attending M.D. decisions -- (2)

B. PIOPED studies completed (check one):

Scan not done ----- (1)
Scan normal ----- (2)
Scan abnormal, angiogram positive ----- (3)
Scan abnormal, angiogram negative ----- (4)
Scan abnormal, angiogram not done ----- (5)

If SCAN NOT DONE complete Form 45.
If SCAN ABNORMAL, ANGIOGRAM NOT DONE and patient is assigned to PIOPED pursuit, complete Form 45.

PART III: Coordination.

7. Is a Supplemental Status Form being filed to communicate additional information? ----- (1) (2)
Yes No

8. Checked for completeness and accuracy:

A. Certification Number: _____

B. Signature: _____

C. Date: _____

Month - Day - Year

Retain a copy of this form for your records. 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