PROSPECTIVE INVESTIGATION OF PULMONARY EMBOLISM DIAGNOSIS

TELEPHONE INTERVIEW FORM

Clinic No.								
ID No.								
Form Type	T	I						

PART I: Identifying Information.

1. Patient's NAME CODE:

   ___ ___ ___ ___ ___

2. Interview date:

   ___ ___ - ___ ___ - ___ ___
   Month Day Year

3. Person obtaining this interview:

   A. Certification Number:

   ___ ___ - ___ ___

   B. Signature:

   _____

4. Has this patient been located (by contacting the patient, a relative, a friend or a health care provider)? ------ (1) Yes (2) No

   If the patient has not been located within the permissible time window, complete as much of this form as possible and send to the DCC.

Record the form type in the appropriate boxes in the upper right-hand corner of this page. Code as:

One month	01
Three months	02
Six months	03
Twelve months	04

PART II: Sources and Data.

5. From whom does the information on this form derive (check all that apply)?

   A. Patient ---------- (1)
   B. Relative ---------- (1)
   C. Friend ---------- (1)
   D. Personal Physician ---------- (1)
   E. PIOPED Clinical Scientist ----- (1)
   F. Medical Office Record ---------- (1)
   G. Hospital Record ---------- (1)
   H. Other, specify ---------- (1)

   _____

6. Vital status

   A. Is this patient alive? -- (1) Yes (2) No

   This variable used to calculate status at follow up: T1, T2, T3 and T4

   If YES, proceed to Item 7.

   B. Place of death:

   _____
   City State

   C. Date of death:

   ___ ___ - ___ ___ - ___ ___
   Month Day Year

   Complete Death Form (PIOPED Form 35) and send to the DCC immediately. Complete Outcome Report Form (PIOPED Form 31) and send to the DCC as soon as possible.

7. Hospitalization

A. Has the patient been readmitted to any hospital since last PIOPED contact? --- (1) Yes (2) No (3) Unk

If NO or UNK, proceed to Item 8.

B. Hospital Name _____

C. Address _____

_____
City State Zip Code

Complete Outcome Report Form (PIOPED Form 31) and send to the DCC as soon as possible.

8. Anticoagulation

A. Has this patient been taking anticoagulants since last PIOPED contact? ---------- (1) Yes (2) No (3) Unk

If NO or UNK, proceed to Item 9.

B. Has the patient experienced any complications of anticoagulation since the last PIOPED contact? --------- (1) Yes (2) No

If NO, proceed to Item 9.

1. Was this a bleeding complication? ------- (1) Yes (2) No

If YES, proceed to Item 8B2.

a. Specify complication

_____

_____

Proceed to Item 9.

8. (Continued)

2. Was this bleeding complication major by PIOPED criteria? ---- (1) Yes (2) No

If YES, complete Outcome Report Form (PIOPED Form 31) and send to the DCC as soon as possible.

9. Has the patient undergone any of the following since last contact:

	Yes	No	Unk
A. Lung scan --------	(1)	(2)	(3)
B. Leg venogram ------	(1)	(2)	(3)
C. Pulmonary angiogram ----------	(1)	(2)	(3)
D. New anticoagulation ---------	(1)	(2)	(3)

If YES to any of Items 9A, 9B, 9C, or 9D, complete Outcome Report Form (PIOPED Form 31) and send to DCC as soon as possible.

If NO or UNK to all of Items 9A, 9B, 9C, and 9D, proceed to Item 10.

E. Name of (first) physician:

_____

F. Physician address:

_____

_____
City State Zip Code

G. Telephone number:

( )
_____
Area Code

H. Name of (second) physician:

_____

I. Physician address:

_____

_____
City State Zip Code

J. Telephone number:

( )
_____
Area Code

ID No. | | | | | | | |

10. New diagnoses:

A. Have any new diagnoses become known on this patient since last contact? ---------- (1) Yes (2) No (3) Unk

If NO or UNK, proceed to Item 11.

B. Diagnoses _____

_____

_____

C. ICD-9 code: 1. ___ ___ ___ ___ . ___

2. ___ ___ ___ ___ . ___

3. ___ ___ ___ ___ . ___

11. Have any of the following symptoms newly occurred or, if previously present, increased in frequency or severity since last contact?

	Yes	No	Unk
A. Dyspnea ----------	(1)	(2)	(3)
B. Pleuritic chest pain ----------	(1)	(2)	(3)
C. Palpitations ------	(1)	(2)	(3)
D. Hemoptysis --------	(1)	(2)	(3)
E. Syncope ----------	(1)	(2)	(3)

PART III: Coordination.

12. 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

ID No.