

Clinic No.					
ID No.					
Form Type	S	P	0	1	

PART I: Identifying Information.

1. Patient's NAME CODE: _____

2. Date study performed: _____

 Month - Day - Year

Used to calculate SCANDYS

3. Technologist:
 A. Certification Number: _____
 B. Signature: _____

PART II: Ventilation Study.

4. Position during study: _____
 Erect _____ (1)
 Supine _____ (2)
 Other, specify _____ (3)

F034

5. Was ventilation study obtained according to protocol? _____ (1) (2)
 Yes No
 A. If NO, specify:

PART III: Perfusion Study.

6. Position during study: _____
 Erect _____ (1)
 Supine _____ (2)
 Other, specify _____ (3)

F036

7. Was perfusion study obtained according to protocol? _____ (1) (2)
 Yes No
 A. If NO, specify:

PART IV: General.

8. Did the patient experience an allergic reaction? _____ (1) (2)
 Yes No
 9. Was the patient intubated? -- (1) (2)

Part V: Coordination.

10. Checked for completeness and accuracy:
 A. Certification Number: _____
 B. Signature: _____
 C. Date: _____

 Month - Day - Year

DCC USE ONLY	
FILMS REC'D	Yes (1) No (2)

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