

PROSPECTIVE INVESTIGATION OF PULMONARY EMBOLISM DIAGNOSIS
 CHEST X RAY PROCEDURE FORM

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

PART I: Identifying Information.

1. Patient's NAME CODE:

2. Date study performed:

Used to calculate CXRDYS

____ - ____ - ____
 Month Day Year

3. Person completing this evaluation:

A. Certification Number:

B. Signature:

PART II: Radiographic Technique.

4. Equipment (check one):

Fixed _____ (1)
 Mobile _____ (2)

5. Beam direction(s) (check all that apply):

A. PA (posteroanterior) _____ (1)
 B. AP (anteroposterior) _____ (1)
 C. Lateral _____ (1)

6. Patient position (check one):

Erect _____ (1)
 Semi-erect _____ (2)
 Supine _____ (3)

F156

Part III: Coordination.

7. 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	
FILMS REC'D	Yes (1)
	No (2)