The variables from this form are combined with those on the form 22, which is why the variable names refer to form 22 questions.

PROSPECTIVE INVESTIGATION OF PULMONARY EMBOLISM DIAGNOSIS

EXTENDED HOSPITAL STAY

Clinic No.						
ID No.						
Form Type	E	H	0	1		

PART I: Identifying Information.

1. Patient's NAME CODE:

   ___ ___ ___ ___ ___

2. Discharge date:

   ___ ___ - ___ ___ - ___ ___
   Month Day Year

3. Individual responsible for completing this form:

   A. Certification number:

   ___ ___ - ___ ___

   B. Signature:

   _____

PART II: Events During Extended Hospital Stay.

4. Was therapy for pulmonary embolism instituted after PIOPED diagnostic studies? -- (1) Yes (2) No F226A

   If NO, proceed to Item 7.

5. Therapy instituted (check all that apply):

   A. Full dose heparin ---------- (1) F226B1

   B. Thrombolytic agents ---------- (1) F226B2

   C. Inferior vena cava interpretation ---------- (1) F226B3

   D. Embolectomy ---------- (1) F226B4

   E. Other, specify ---------- (1) F226B5

   _____

6. Complications

   A. Were there any complications of therapy for pulmonary embolism? ----- (1) Yes (2) No F226C1

   If NO, proceed to Item 7.

   B. Category of complication(s):

   1. Hemorrhagic --------- (1) Yes (2) No F226C2

   If NO, proceed to Item 6B2.

   Severity of hemorrhagic complication(s) (check all that apply):

   a. Major ---------- (1) F226C2A1
   b. Minor ---------- (1) F226C2A2

   If MAJOR, complete PIOPED Form 31 (OUTCOME REPORT).

	Yes	No	
2. Vascular ----------	(1)	(2)	F226C2B
3. Perioperative -------	(1)	(2)	F226C2C
4. Other, specify ------	(1)	(2)	F226C2D

   _____

   _____

   _____

7. Were new or recurrent pulmonary emboli suspected between the time initial PIOPED imaging studies were completed to the end of the period covered on this form? ---------- (1) Yes (2) No

   If YES, complete PIOPED Form 31 (OUTCOME REPORT).

8. Discharge blood gas analysis:

A. Availability:

Done ---------- (1)
Not done ---------- (2)

If NOT DONE, proceed to Item 9.

B. Date and time: __ __ - __ __ - __ __ (Month Day Year) __ __ : __ __ (24 hour clock)

C. Delivery apparatus and O_2 delivered (complete one line):

(1)		(2)
None	(01)	Room Air
Mask	(02)	__ __ __ % O_2
Tent	(03)	__ __ __ % O_2
Endotracheal tube	(04)	__ __ __ % O_2
Nasal prongs	(05)	__ __. __ liters O_2/minute
Hyperbaric chamber	(06)	__ . __ atmospheres O_2
Other, specify	(07)	_____

D. Tensions and activities:

1. pH ---------- __. __ __
2. P_aO_2 ---------- __ __ __ mm Hg
3. P_aCO_2 ---------- __ __ __ mm Hg

PART III: Discharge.

9. Disposition (check one): F2215

Deceased ---------- (1)
Acute care hospital ---------- (2)
Nursing home care ---------- (3)
Rehabilitation hospital ---------- (4)
Home or other private residence ---------- (5)
Other, specify ---------- (6)

_____

If DECEASED, proceed to Item 12.

10. Activity status (check one): F2216

Bedridden ---------- (1)
Up in chair only ---------- (2)
Limited ambulation ---------- (3)
Full ambulation ---------- (4)

11. Discharge medications:

	Yes	No	
A. Was the patient discharged on anticoagulant or antiplatelet agents?	(1)	(2)	MEDA

If NO, proceed to Item 12.

B. Platelet active agents	(1)	(2)	MEDB
C. Full dose heparin	(1)	(2)	MEDC
D. Adjusted dose heparin	(1)	(2)	MEDD
E. Mini dose heparin	(1)	(2)	MEDE
F. Oral anticoagulants	(1)	(2)	MEDF

ID No. | | | | | | |

12. Pulmonary angiography

A. Did this patient undergo pulmonary angiography at any time during this hospitalization? -------- (1) Yes (2) No

If NO, proceed to Item 13.

12. (Continued)

B. When was the pulmonary angiography performed?

1. Date

___ ___ - ___ ___ - ___ ___
Month Day Year

2. Time

___ ___ : ___ ___
24 hour clock

---

13. Discharge diagnoses (from hospital chart front sheet):

		(A)	(B) ICD-9 Code
Primary ------	1.	_____	___ ___ ___ ___ . ___
Seconary -----	2.	_____	___ ___ ___ ___ . ___
	3.	_____	___ ___ ___ ___ . ___
	4.	_____	___ ___ ___ ___ . ___
	5.	_____	___ ___ ___ ___ . ___
	6.	_____	___ ___ ___ ___ . ___
	7.	_____	___ ___ ___ ___ . ___

PART IV: Coordination.

14. 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 of this form 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. | | | | | | |