

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