



L-PVDOMICS STUDY

Center Chest CT Scan Images and Report

Transmittal Form #653

Instructions: One Form 653 is completed for each participant's level of participation (L1, L2, L3). This form allows the center to identify whether or not a CT scan was done and images are available for Core review. An email notification will be sent by the database to the Lung Imaging Core (**LIC**) to expect transmitted report and data for this participant.

Note:

- 1) Chest CT scan including images and final report can be obtained from PVDOMICS center or an outside medical facility
- 2) CT must be at least 6 months past the enrollment date of the PVDOMICS (parent) Study
- 3) CT must not be more than 3 months prior to or after Form 500 L-PVDOMICS Study enrollment date
- 4) If multiple CT scans, use images closest to the Form 500 L-PVDOMICS Study enrollment date.
- 5) **Label L-PVDOMICS Study CT images and CT final report as: LCT_XXXXX_XX_MMDDYYYY**

--	--	--	--	--	--

1. Identification Number

--	--

2. Alphacode

--	--	--	--	--	--	--	--

3. Date of chest CT or review (mm/dd/yyyy)

4. Was a chest CT done? _____
 0=No, chest CT scan not done during time period of medical record review
 1=Yes, scan completed and images available for CT Core review.
 9=Unknown (If CT scan was not done or unknown, skip to Q200.)

5. Type of scan _____
 1=Chest CT without contrast (Non-contrast Chest CT)
 2=Chest CT with contrast (Routine post contrast CT)
 3=Chest CT with angiogram (Chest CTA PE protocol)
 9=Unknown

6. Is final report from local radiologist available and de-identified? (0=No, 1=Yes) _____

Please label images and final report for L-PVDOMICS Study as:

LCT_XXXXX_XX_MMDDYYYY

7. a. Date de-identified images transmitted to LIC (mm/dd/yyyy) ____/____/_____
 b. Date de-identified report transmitted via secure portal (mm/dd/yyyy).. ____/____/_____
 8. Type of image format file transmitted to LIC (1=DICOM, 2=Other format) _____

199. Username of person transferring images to Core _____
 (First 6 letters of last name followed by first letter of first name)

200. Date this form completed (mm/dd/yyyy) ____/____/_____
 201. Username of person completing/reviewing completeness of this form _____

Clinical Center Use Only

Date Form Entered (mm/dd/yyyy) ____/____/_____
 Username of person entering this form _____