LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
SUBJECT SCREENING FORM

ID Number: 0 0 - ■ ■ ■ ■ - ■
Letter Code: ■ ■ ■ 0 1
Form Type: vis_dt

1. Date subject was enrolled: ___ ___ __ - ___ __ - ___ ___
   Month   Day   Year

I. SCREENING INFORMATION

1. Has the patient previously enrolled in the LTRC?
   Yes (1) No (2) prvenrl
   IF NO, go to question 2.

   A. Date subject was last enrolled: ___ ___ __ - ___ __ - ___ ___
      Month   Day   Year

   B. Previous ID number in the LTRC: 0 _ _ _ _ _ _ _ _ _ _
      prve_dt

2. Inclusion criteria:

   A. Is the subject age 21 or above?
      Yes (1) No (2) age21

   B. Does the subject have a clinical indication of ILD
      leading to VATS or open lung biopsy?
      (1) (2) illdiag

   C. Does the subject have COPD leading to treatment with
      lung volume reduction surgery?
      (1) (2) copdlvrs

   D. Does the subject have a clinical indication of ILD (including
      fibrosis, UIP, NSIP, or Sarcoidosis) or COPD as the
      principal reason for lung transplantation?
      (1) (2) ipfcopd2

   E. Does the subject have a lung nodule/mass leading
      to resection?
      (1) (2) lungmass

   F. Clinical indication for lung surgery is ILD:
      (1) (2) surgipf

3. Exclusion Criteria:

   A. Has the patient been diagnosed with an active
      primary infectious process (e.g. tuberculosis)?
      (1) (2) priminf
      STOP*

   B. Is there a primary diagnosis of cystic fibrosis,
      berylliosis or pulmonary hypertension listed as the
      reason for a transplant?
      (1) (2) excldia2
      STOP*
4. Has the patient signed a consent form? 
   Yes  (1)  No  (2) consent STOP

   The patient is eligible if all of the following are true:
   - Questions 2A and 4 are checked YES
   - At least 1 of questions 2B, C, D, or E is checked YES
   - Both questions 3A and 3B are checked NO.

5. Is the patient eligible for the LTRC?  (1)  (2) eligible STOP
   *If this is checked, the patient is not eligible for the LTRC.

II. ADMINISTRATIVE MATTERS
1. General Comments: ________________________________________________
   __________________________
   __________________________

2. Principal or Co-Investigator:
   A. Signature: ______________________________________________________ pi_sig
   B. LTRC Staff No. ___ ___ ___ - ___ ___ ___ pi_no

3. Research Coordinator:
   A. Signature: ______________________________________________________ cert_sig
   B. LTRC Staff No. ___ ___ ___ - ___ ___ ___ cert_no

4. Date Form Completed: _______ - _______ - 2 _______ _______ compl_dt
   Month    Day    Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
DEMOGRAPHIC QUESTIONNAIRE

ID Number: 00-0-0-0
Letter Code: 
Form Type: D Q 0 1

1. Date of Interview: _ _ _ _ _ _ - _ _ _ - _ _ _ _ _ _
   Month Day Year

I will be asking some questions about your background.

I. DEMOGRAPHICS

1. What is your birth date? _ _ _ _ _ _ - _ _ _ _ _ _ _ _
   Month Day Year

2. What is your gender?
   Male (1)
   Female (2)

3. What is your ethnicity?
   Hispanic or Latino (1)
   Not Hispanic or Latino (2)
   Chooses Not to Disclose (3)

4. What race(s) do you primarily identify with (Check all that apply)?
   INTERVIEWER READ LIST
   A. American Indian or Alaskan Native (1)
   B. Asian (1)
   C. Black or African American (1)
   D. Native Hawaiian or other Pacific Islander (1)
   E. White (1)
   F. Chooses Not to Disclose (1)
II. ADMINISTRATIVE MATTERS

1. General comments:

   ___________________________________________________________________

   ___________________________________________________________________

2. Research coordinator:

   A. Signature: ___________________________________________________________________

   B. LTRC Staff No.: __ __ __ - __ __ __

3. Date Form Completed: __ __ __ - __ __ - __

   Month  Day  Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CHANGE OF PROCEDURE/DEACTIVATION FORM

ID Number: 0 0 - - - 
Letter Code: 
Form Type: D F

This form is to be completed when an expected procedure is not done or when a patient is deactivated from the study.

1. Date of report:
   Month - Day - Year

vis_dt

I. CHANGE OF PROCEDURE

If the patient has no procedure change, skip to Section II (i.e., this is a notice of deactivation only).

1. Interval for change of procedure (check only one)
   Enrollment (01)
   6 Month (02)
   12 Month (03)
   18 Month (04)
   24 Month (05)
   30 Month (06)
   36 Month (07)
   42 Month (08)
   48 Month (09)
   54 Month (10)
   60 Month (11)

interval

2. Procedure (check all that apply)
   Missed Enrollment Only
   A. Questionnaire(s) (1) misques
   B. Cardiopulmonary Exercise Testing (1) miscpx
   C. Six-Minute Walk Test (1) mis6mwlk
   D. Pulmonary Function Testing (1) mispft
   E. Laboratory Data (1) mislab
   F. Research Blood Collection (1) misblld
   G. CT Scan (1) misct
   H. Concomitant Therapy (1) misther

For transplant patients, skip Item 2I.

I. Tissue Collection
   Not Collected (1)
   Delayed (2) Enrollment Only

misstiss

Non-transplant patients whose tissue collection is delayed for more than six months are expected to repeat procedures listed in 2C – 2H every six months until tissue is collected.
II. PATIENT DEACTIVATION

If the patient has not deactivated from the study, skip to Section III (i.e., this is only a notice of a change in procedure).

1. Date of deactivation: __ __ - __ __ - __ __ __ __
   Month   Day   Year

2. Reason for deactivation (select only one)
   Subject is dead (1)
   Subject is unwilling to participate (2)
   Lost to follow-up (3)
   Surgery Cancelled (4)
   Other (5)

   A. Specify ____________________________

3. Status of:

   Can be Used  Cannot Be Used  Not Collected
   A. Tissue (1) (2) (3)
   B. Blood (1) (2) (3)
   C. CT Scan (1) (2) (3)

III. ADMINISTRATIVE MATTERS

1. General Comments: ________________________________

2. Research Coordinator:
   A. Signature: ________________________________
   B. LTRC Staff No. __ __ __ __ __ __ __ __ __ __

3. Date form completed: __ __ - __ __ - __ __ __ __
   Month   Day   Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
MEDICAL HISTORY QUESTIONNAIRE

ID Number: 0 0
Letter Code: M H 0 1
Form Type: vis_dt

1. Date of Interview: Month  Day  Year

I. PAST ILLNESSES

1. Now, I am going to read you a list of health problems. For each health problem, please tell me if you have ever had the problem.

   A. Angina
   B. Heart failure (congestive heart failure or congestive heart disease)
   C. Thromboembolic (blood clots in leg or lung)
   D. Arrhythmia (irregular heart beat)
   E. Hyperlipidemia (high cholesterol)
   F. Renal Failure (kidney failure)
   G. Hepatitis (Liver infection or inflammation)
   H. Cirrhosis or other serious, chronic liver disease
   I. Diabetes
   J. HIV
   K. Lung Cancer
   L. Other Cancer (excluding basal cell carcinoma)
       1) If YES, then specify:

   M. Rheumatoid Arthritis
   N. Scleroderma
   O. Lupus
   P. Polymyositis
   Q. Other collagen vascular disease
       1) If YES, specify:

   Yes (1)  No (2)  Don’t Know (3)
   angina  chf  thrmemb  arrhythm  hyllipid  renfail  hepatis  cirrhos  diabetes  hiv  lungcanc  othcanc  canc_sp  arthrits  sclerdm  lupus  polymos  colvasc  vasc_sp
R. Gastroesophageal Reflux Disease (GERD)
S. Asthma
T. Pulmonary Hypertension

2. Have you ever had attacks of bronchitis?
   A. Was it confirmed by a doctor?
   B. At what age was your first attack?

3. Have you ever had respiratory failure requiring a ventilator?

4. Have you unexpectedly lost a lot of weight in the past three months? (A lot is 10% or more of your body weight).

5. Have you had any of the following surgical procedures?
   A. Tracheotomy/Tracheostomy
   B. Bullectomy, pneumonectomy, or lobectomy (removal of all or part of the lung)/Prior surgical lung biopsy

If NO to B, go to D.
C. Which lung(s) and lobe(s) did you have the procedure on? (Please check all that apply.)

1) Right Upper (1) surg_ru
2) Right Middle (1) surg_rm
3) Right Lower (1) surg_rl
4) Left Upper (1) surg_lu
5) Lingula (1) surg_lq
6) Left Lower (1) surg_ll
7) Don't Know (1) surg_dn

D. Any other chest operations?

1. If YES to D, Specify: ________________________________

6. Have you ever had any chest injuries?

A. If YES to Question 6, Specify: _______________________________________

II. CURRENT ILLNESSES

1. Has a doctor told you that you have any of the following? Yes No Don't Know

A. Chronic Obstructive Pulmonary Disease (COPD) (1) (2) (3) copd_cur
B. Chronic Bronchitis (1) (2) (3) brnc_cur
C. Emphysema (1) (2) (3) emph_cur
D. Asthma (1) (2) (3) asth_cur

2. Do you have alpha-1 antitrypsin deficiency? (1) (2) (3) aladefc

3. Has a doctor told you that you have a fibrotic lung disease? (1) (2) (3) fibrldis

   **If NO or DON'T KNOW, go to Part III.**

4. Was the fibrotic lung disease documented by surgical biopsy? Yes No Don't Know (1) (2) (3) flddoc
III. ADMINISTRATIVE MATTERS

1. General Comments: __________________________________________________________
   __________________________________________________________________________
   ___________________________ gen_cmnt

2. Research Coordinator:
   A. Signature: ________________________________________________________________
      _________________________________________________________________________
      ___________________________ cert_sig
   B. LTRC Staff No. ________ ______ - ________
      ___________________________ cert_no

3. Date form completed: ________ ______ - ________ - ________
   Month        Day  Year
      ___________________________ compl_dt
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
FAMILY HISTORY QUESTIONNAIRE

ID Number: 0 0 - - -
Letter Code:
Form Type: F H 0 1

1. Date of Interview: __ __ __ - __ __ - 2 __ __ __
   Month Day Year

GENERAL INSTRUCTIONS: ASK PARTICIPANT ALL QUESTIONS, SKIPPING OVER
SECTIONS WHEN APPROPRIATE.

Beginning Script:
The following questions have to do with your blood relatives (for example your birth mother,
your birth father, brother, sister, child). Please answer these questions to the best of your
knowledge. If you are unsure of any of the answers, please respond with “I don’t know”.
Remember, these questions are about blood relatives.

I. FIRST DEGREE BLOOD RELATIVES

1. Do you know who at least one of your birth parents are? Yes No parents
   (1) (2)
   Please answer NO if you only know about your adoptive, foster or step-parents.

2. How many blood siblings do you have (include half siblings)? ___ ___ (1) sib_unk

3. How many children do you have? ___ ___ (1) childunk

IF ITEM 1 IS YES OR ITEM 2 OR 3 HAS A NUMBER
GREATER THAN ZERO, ASK ALL REMAINING QUESTIONS.
4. Have any of your first degree blood relatives (parent, sibling, child) developed any of the following?

A. COPD
B. Chronic bronchitis
C. Emphysema
D. Asthma

Yes  No  Unknown
(1)  (2)  (3)
rel_copd
rel_bron
rel_emph
rel_asth

5. Have any of your first degree blood relatives (parent, sibling, child) had alpha-1 antitrypsin deficiency?

Yes  No  Unknown
(1)  (2)  (3)
rel_alad

6. Have any of your first degree blood relatives (parent, sibling, child) developed a fibrotic lung disease?

Yes  No  Unknown
(1)  (2)  (3)
rel_fld

IF NO OR UNKNOWN, GO TO QUESTION 8.

7. Was a fibrotic lung disease documented by biopsy in any of these relatives?

Yes  No  Unknown
(1)  (2)  (3)
rel_biop

8. Have any of your first degree blood relatives had any of the following?

A. Rheumatoid arthritis
B. Scleroderma
C. Lupus
D. Polymyositis
E. Other collagen vascular disease
   1) If YES to E, specify: _______________________________________
F. Pulmonary Hypertension

Yes  No  Unknown
(1)  (2)  (3)
rel_arth
rel_sclr
rel_lups
rel_pmyo
rel_ovas
rel_sp
rel_phyp
II. ADMINISTRATIVE MATTERS

1. General Comments: 

2. Research Coordinator:
   A. Signature: 
   B. LTRC Staff No. ___ ___ ___ - ___ ___ ___

3. Date Form Completed: ___ ___ ___ - ___ ___ - 2 ___ ___
   Month   Day   Year
LUNG TISSUE RESEARCH CONSORTIUM
SMOKING HISTORY FORM

ID Number: 0 0 - __________ - __________
Letter Code: __________
Form Type: S H 0 1

1. Date of Interview: __________ - __________ - __________ (vis_dt)
   Month    Day    Year

I. SMOKING HISTORY

1. CIGARETTES
   A. Have you ever smoked at least 100 cigarettes in your lifetime? (not cigars or pipes)
      Yes (1)    No (2) (smokcig)

   B. Do you now smoke cigarettes?
      Yes (1)    No (2) (smoknow)

   C. When smoking cigarettes, what is the average number of cigarettes you smoked per day?
      _______ cigarettes per day (cignum)

   D. On average, how many years in total have you smoked cigarettes?
      _______ Years (cigyrs)

   If you are a current smoker, skip E and go to 2A.

   E. When did you stop smoking cigarettes?
      Month _______ - Year _______ (cstopmon - cstopyr)

2. CIGARS/CIGARILLOS/PIPES
   A. Have you ever smoked at least 100 cigars, cigarillos or pipes in your lifetime?
      Yes (1)    No (2) (smokoth)

   IF NO, GO TO 3A.
B. Do you now smoke cigars, cigarillos or pipes?  

C. When smoking, what is the average number of cigars, cigarillos or pipe bowls you smoke in a day? 

- Less than one (1)
- one – two daily (2)
- three – four daily (3)
- five – seven daily (4)
- Eight or more daily (5)

D. On average, how many years in total have you smoked cigars, cigarillos, or pipes?  

If you are a current smoker, skip E and go to 3A.

E. When did you stop smoking cigars, cigarillos, or pipes?  

3. PASSIVE SMOKE EXPOSURE

A. Have you ever lived in a household in which people smoked?  

B. Have you ever worked in an environment with significant second-hand smoke exposure?  

If NO or DON'T KNOW to A and B, go to D.

C. How long were you exposed to second-hand smoke in your home or work environment?  

D. Did your mother smoke while she was pregnant with you?
II. ADMINISTRATIVE MATTERS

1. General Comments: ________________________________________________________________

2. Research Coordinator:
   A. Signature: ________________________________________________________________
   B. LTRC Staff Number: ___ ___ ___ - ___ ___ ___

3. Date Form Completed: ___ ___ ___ - ___ ___ ___ - 2 - ___ ___
   Month     Day     Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CONCOMITANT THERAPY FORM

ID Number: 0 0 [ ] [ ] [ ] - [ ] [ ] [ ] [ ]
Letter Code: [ ] [ ] [ ]
Form Type: C T [ ] [ ]

1. Date of Interview: [ ] [ ] - [ ] [ ] - [ ] [ ]
   Month Day Year

I. SPECIFIC MEDICAL TREATMENT INFORMATION

1. Have you taken the following medications in the 30 days prior to today?
   Yes No
   (1) (2) ssteroid
   (1) (2) interfkn
   (1) (2) immmsupp

   A. Systemic (Oral or IV) corticosteroids
      (e.g. prednisone, Medrol)
   B. Interferon (gamma or beta)
   C. Immune suppressive agents
      (such as cyclophosphamide, azathioprine,
       mycophenolate, TNF-alpha antagonists,
       methotrexate, or other immune suppressive
       agents or investigational drugs)

2. Have you ever taken the following medications?
   If YES, please specify the duration (number of years)
   of use and how long ago (in years) you stopped.

   (1) (2) (3)
   Ever Duration How
   Number of Long
   Years ago
   [ ] [ ] [ ]
   Yes No amio_dur amio_stp
   nitr_dv nitr_stp
   chem_dv chem_stp

   A. Amiodarone
   B. Nitrofurantoin
   C. Chemotherapy for cancer
      (such as Bleomycin, cyclophosphamide,
      ARA-C, Nitrosoureas, Gemcytbine,
      Imuran, Iressa)
   D. Thoracic Radiation Therapy for Malignancy
      trad_ev trad_dur trad_stp
II. OTHER MEDICATION INFORMATION

1. Have you taken any inhaled steroids (e.g. Flovent, Pulmicort, Aerobid, Advair) in the last 30 days?  
   Yes  No  
   (1)  (2)  isteroid

2. Have you taken any of the following types of bronchodilator medication in the last 30 days?
   A. Inhaled beta-agonists such as Serevent, salmeterol, Ventolin, Proventil, Albuterol, Foradil 
      Yes  No  
      (1)  (2)  bronchdl
   B. Anticholinergics such as Atrovent, Combivent, Spiriva  
      (1)  (2)  bronchd2
   C. Oral beta-agonists, such as Brethaire, Ventolin, Proventil.  
      (1)  (2)  bronchd3
   D. Theophylline  
      (1)  (2)  bronchd4
   E. Other  
      (1)  (2)  bronchd5

1) If YES to E, specify: ____________________________  

bron_d_sp

3. Have you taken any of the following types of medications within the last 30 days? If YES, please specify the duration (number of years) of use.

   A. Ace Inhibitor  
      aceinhib  (1)  (2)  _______  ace_dur
   B. Statins  
      statins  (1)  (2)  _______  stat_dur
   C. Macrolides  
      macrolid (1)  (2)  _______  macr_dur
   D. Cox-2 Inhibitors  
      cox2inhib (1)  (2)  _______  cox2_dur
   E. Ketaconazole  
      ketacon (1)  (2)  _______  keta_dur

   (1) In The Last 30 Days  (2) Duration  
   Yes  No  Number of years
III. ADMINISTRATIVE MATTERS

1. General Comments: __________________________________________________________
   __________________________________________________________

2. Research Coordinator:
   A. Signature: __________________________________________________________

   B. LTRC Staff No: _______ - _______ _______ __________

3. Date form completed: _______ - _______ - _______ _______ __________
   Month    Day    Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)

SYMPTOM QUESTIONNAIRE

ID Number: 0 0 - 
Letter Code: 
Form Type: S Q 0 1

1. Date of Interview: ___ ___ - ___ - ___ ___ 
   Month   Day  Year

I. COUGH

These questions pertain mainly to your chest. Please answer YES or NO. If you are in doubt about whether your answer is YES or NO, then answer NO.

1. Do you usually have a cough? 
   Yes  No  
   (1)  (2)  
   (Count a cough with first smoke or on first going out-of-doors). Exclude clearing your throat.
   If NO, go to Question 3.

2. Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week?  
   (1)  (2)  
coughdy

3. Do you usually cough all on getting up, or first thing in the morning? 
   (1)  (2)  
cougham

4. Do you usually cough all during the rest of the day or night?  
   (1)  (2)  
coughpm

5. Do you usually cough like this on most days for three consecutive months during the year?  
   (1)  (2)  
coughmo

6. For how many years have you had this cough? ___ ___ Years  
coughyrs
II. PHLEGM

1. Do you usually bring up phlegm from your chest? Yes   No
   (1)   (2) phlegm

   Count phlegm with the first smoke or on first going out-of-doors. Exclude phlegm from the nose. Count swallowed phlegm.

   If NO, go to Question 3.

2. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week? (1)   (2) phlegmdy

3. Do you usually bring up phlegm at all on getting up, or first thing in the morning? (1)   (2) phlegmam

4. Do you usually bring up phlegm at all during the rest of the day or at night? (1)   (2) phlegmpm

   If YES to any of questions 1-4, go to Question 5. If NO to all, go to Part III.

5. Do you bring up phlegm like this on most days for three consecutive months or more during the year? (1)   (2) phlegmmo

6. For how many years have you had trouble with phlegm? ___ ___ Years phlegmyr

III. EPISODES OF COUGH AND PHLEGM

If question 1 in Part I was answered NO, go to Part IV.

1. Have you had periods or episodes of increased cough and phlegm lasting for three weeks or more each year? Yes   No
   (1)   (2) epiwks

   If NO, go to Part IV.

2. For how long have you had at least one such episode per year? ___ ___ Years epiys
epiyr

   Don't Know epiyr_dk (1)
IV. WHEEZING

1. Does your chest ever sound wheezy or whistling? Yes __ No __
   A. When you have a cold? (1) (2)
   B. Occasionally, apart from colds? (1) (2)
   C. Most days or nights? (1) (2)

   If NO, to all of the above, go to Question 3.

2. For how many years has this been present? ___ Years

3. Have you ever had an attack of wheezing that has made you feel short of breath? Yes __ No __

   If NO, go to Part V.

4. How old were you when you had your first attack? ___ Years

5. Have you had two or more such episodes? Yes __ No __

6. Have you ever required medicine or treatment for the(se) attack(s)? Yes __ No __

7. Have you had an attack of wheezing that has made you feel short of breath in the past year? Yes __ No __

   If NO, go to Part V.

8. Have you had two or more such episodes in the past year? Yes __ No __

9. Have you required medicine or a treatment for the(se) attack(s) in the past year? Yes __ No __

V. BREATHLESSNESS

1. Are you disabled from walking by any condition OTHER than heart or lung disease? Yes __ No __

   If YES, please describe the nature of the condition(s):
   A. 

   cantwalk

   walk_sp
2. The following questions are designed to determine how much work would make you short of breath. Please answer each question. If you use supplemental oxygen please answer each question as though you are NOT using your oxygen.

A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?
   Yes No
   (1) (2)
   shrbrhil

   If NO to A, go to Part VI.

B. Do you have to walk slower than people of your age on the level because of breathlessness?
   Yes No
   (1) (2)
   walkslow

C. Do you ever have to stop for breath when walking at your own pace on the level?
   Yes No
   (1) (2)
   walkstop

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?
   Yes No
   (1) (2)
   walkdist

E. Are you too breathless to leave the house or breathless on dressing or undressing?
   Yes No
   (1) (2)
   cantleav

VI. CHEST COLDs AND CHEST ILLNESSES

1. How often do you get colds?
   - Less often than once a year
   - Once a year
   - 2-4 times per year
   - 5 or more times per year
   (1) (2) (3) (4)
   otcold

   If LESS THAN ONCE A YEAR, go to Question 5.

2. Do your colds usually go to your chest? ("Usually" means more than half the time).
   Yes No
   (1) (2)
   chstcold

3. How often did you get colds in the past 12 months?
   - Not at all
   - Once
   - 2-4 times
   - 5 or more times
   (1) (2) (3) (4)
   otcold2

   If NOT AT ALL, go to Question 5.
4. Did your colds in the past 12 months usually go to your chest? (*"Usually" means more than half the time). 
   Yes \( (1) \) No \( (2) \) chstoft

5. During the past 12 months, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? 
   Yes \( (1) \) No \( (2) \) chstyr
   If NO, go to Question 8.

6. Did you produce phlegm with any of these chest illnesses? \( (1) \) \( (2) \) chstphlm

7. In the past 12 months, how many such illnesses, with (increased*) phlegm, did you have which lasted a week or more? 
   *(for persons who usually have phlegm) No. of Illnesses \( \ldots \) \( \ldots \) chstnbr

8. Did you have any lung trouble before the age of 16? 
   Yes \( (1) \) No \( (2) \) lung16

9. Did you have any chest illness before the past 12 months? 
   \( (1) \) \( (2) \) chsill12
   A. If YES to question 9, specify: __________________________

VII. ADMINISTRATIVE MATTERS

1. General Comments: ___________________________________________ gen_cmnt
   ___________________________________________

2. Research Coordinator:
   A. Signature: ___________________________________________ cert_sig
   B. LTRC Staff Number: ________ - ________

3. Date Form Completed: __________ - __________ - 2 __________ Year
   Month Day Year
   compl_dt
**LUNG TISSUE RESEARCH CONSORTIUM (LTRC)**
**SF-12 HEALTH SURVEY**

<table>
<thead>
<tr>
<th>ID Number:</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter Code:</td>
<td>H</td>
<td>S</td>
</tr>
</tbody>
</table>

1. Date of Interview: ___ ___ - ___ ___ - 2 ___ ___ (vis_dt)
   Month   Day   Year

## I. EVALUATION

**General Instructions:** This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

For each of the following questions, please mark the space that best describes your answer.

1. **In general, would you say your health is:**

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

2. The following questions are about activities you might do during a typical day. **Does your health now limit you in these activities?** If so, how much?

   **Yes, limited a lot**
   **Yes, limited a little**
   **No, not limited at all**

   **A. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf**
   (1) (2) (3)

   **B. Climbing several flights of stairs**
   (1) (2) (3)

3. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

   **Accomplished less than you would like**
   **Were limited in the kind of work or other activities**

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

4. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

   **Accomplished less than you would like**
   **Did work or other activities less carefully than usual**

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>
5. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

6. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks . . .

   A. Have you felt calm and peaceful?  
      (1) All of the time  (2) Most of the time  (3) Some of the time  (4) A little of the time  (5) None of the time
      anxiety1
      anxiety2
      anxiety3

   B. Did you have a lot of energy?  
      (1) All of the time  (2) Most of the time  (3) Some of the time  (4) A little of the time  (5) None of the time

   C. Have you felt downhearted and depressed?  
      (1) All of the time  (2) Most of the time  (3) Some of the time  (4) A little of the time  (5) None of the time

7. During the past 4 weeks, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

II. ADMINISTRATIVE MATTERS

1. General Comments: 

   

2. Research Coordinator:
   A. Signature: 
   B. LTRC Staff Number: ___ ___ ___ - ___ ___ ___

3. Date Form Completed: ___ ___ - ___ ___ - 2 ___ ___ 
   Month   Day   Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
ST. GEORGE’S RESPIRATORY QUESTIONNAIRE

ID Number: 0 0 - ___________ - ______
Letter Code: R Q 0 1
Form Type: ___________ - ___________ - ______

Date of Interview: ________ - ________ - 2 ________ Year

I. EVALUATION

This questionnaire is designed to help us learn much more about how your breathing is troubling you and how it affects your life. We are using it to find out which aspects of your illness cause you the most problems, rather than what the doctors and nurses think your problems are.

Please read the questions carefully and ask if you do not understand anything. Do not spend too long deciding about your answers.

Please describe how often your lung/respiratory problems have affected you over the last four weeks.

Part 1: Four week description. Please describe how often your lung/respiratory problems have affected you over the last four weeks. Please check one answer for each question.

1. Over the last 4 weeks, I have coughed:
   - Almost every day (1)
   - Several days a week (2)
   - A few days a month (3)
   - Only with lung/respiratory infections (4)
   - Not at all (5)

2. Over the last 4 weeks, I have brought up phlegm (sputum):
   - Almost every day (1)
   - Several days a week (2)
   - A few days a month (3)
   - Only with lung/respiratory infections (4)
   - Not at all (5)

3. Over the last 4 weeks, I have had shortness of breath:
   - Almost every day (1)
   - Several days a week (2)
   - A few days a month (3)
   - Only with lung/respiratory infections (4)
   - Not at all (5)
4. Over the last 4 weeks, I have had episodes of wheezing:
   - Almost every day
   - Several days a week
   - A few days a month
   - Only with lung/respiratory infections
   - Not at all
   wheez4wk

5. During the last 4 weeks, how many severe or very unpleasant episodes of lung/respiratory problems have you had:
   - More than three episodes
   - Three episodes
   - Two episodes
   - One episode
   - No episodes
   resp4wk

6. How long did the worst episode of lung/respiratory problem last:
   - A week or more
   - Three or more days
   - One or two days
   - Less than a day
   resplen

7. Over the last 4 weeks, in an average week, how many good days (with few lung/respiratory problems) have you had:
   - None
   - One or two
   - Three or four
   - Nearly every day
   - Every day
   gddly4wk

8. If you wheeze, is it worse in the morning?
   - No
   - Yes
   wheezam
Part 2 – Section 1

9. How would you describe your lung/respiratory condition (check one only):
   The most important problem I have (1)
   Causes me quite a lot of problems (2)
   Causes me a few problems (3)
   Causes no problem (4)

10. If you have ever held a job, please check one of these:
    My lung/respiratory problem made me stop my job (1)
    My lung/respiratory problem interferes with my job or made me change my job (2)
    My lung/respiratory problem does not affect my job (3)

Section 2: These are questions about what activities usually make you feel short of breath. Please check either True or False as it applies to you now.

11. Sitting or lying still: True (1) False (2) sbact1
12. Washing yourself or dressing: (1) (2) sbact2
13. Walking in the house: (1) (2) sbact3
14. Walking outside on level ground: (1) (2) sbact4
15. Walking up a flight of stairs: (1) (2) sbact5
16. Walking up hills: (1) (2) sbact6
17. Playing sports or active games (baseball, tennis, etc.): (1) (2) sbact7
Section 3: These are more questions about your cough and shortness of breath. Please check either True or False as it applies to you now.

18. Coughing hurts:  
   True (1)  False (2)  cghhurt
19. Coughing makes me tired:  
   (1)  (2)  cghtrt
20. I am short of breath when I talk:  
   (1)  (2)  sbtalk
21. I am short of breath when I bend over:  
   (1)  (2)  sbbend
22. My coughing or breathing disturbs my sleep:  
   (1)  (2)  sbsleep
23. I become exhausted easily:  
   (1)  (2)  exhstd

Section 4: These are questions about other effects that your lung/respiratory problems may have on you. Please check either True or False as it applies to you now.

24. My coughing or breathing is embarrassing in public:  
   True (1)  False (2)  respeff1
25. My lung/respiratory problem is a nuisance to my family, friends, or neighbors:  
   (1)  (2)  respeff2
26. I panic or get afraid when I cannot catch my breath:  
   (1)  (2)  respeff3
27. I feel that I am not in control of my lung/respiratory problem:  
   (1)  (2)  respeff4
28. I do not expect my lung/respiratory problem to get any better:  
   (1)  (2)  respeff5
29. I have become frail or an invalid because of my lung/respiratory problem:  
   (1)  (2)  respeff6
30. Exercise is not safe for me:  
   (1)  (2)  respeff7
31. Everything seems too much of an effort:  
   (1)  (2)  respeff8
Section 5: These are questions about your lung/respiratory medication, including oxygen, inhalers and pills. If you are not receiving medications, go to Section 6. To complete this section, check either True or False as it applies to you now.

32. My lung/respiratory medication does not help me very much: True (1) False (2) resprx1
33. I get embarrassed using my lung/respiratory medication in public: (1) (2) resprx2
34. I have unpleasant side effects from my lung/respiratory medication: (1) (2) resprx3
35. My lung/respiratory medication interferes with my life a lot: (1) (2) resprx4

Section 6: These are questions about how your activities might be affected by your breathing problem. For each question, please check True if one or more parts applies to you because of your breathing problem. Otherwise, check False.

36. I take a long time to get washed or dressed: True (1) False (2) respect1
37. I cannot take a bath or shower, or I take a long time: (1) (2) respect2
38. I walk slower than other people my age, or I stop to rest: (1) (2) respect3
39. Jobs such as household chores take a long time, or I have to stop to rest: (1) (2) respect4
40. If I walk up one flight of stairs, I have to go slowly or stop: (1) (2) respect5
41. If I hurry or walk fast, I have to stop or slow down: (1) (2) respect6
42. My breathing makes it difficult to do things such as walking up hills, carrying things up stairs, light gardening such as weeding, dancing, playing golf, or light sports such as horsehoes: (1) (2) respect7
43. My breathing problem makes it difficult to do things such as carrying heavy loads, like digging in the garden or shoveling snow, jogging or walking briskly, playing tennis or swimming: (1) (2) respect8
44. My breathing problem makes it difficult to do things such as very heavy manual labor, riding a bike, running, swimming fast or playing competitive sports: (1) (2) respect9
Section 7: We would like to know how your breathing usually affects your daily life. Please check either True or False as it applies to you because of your lung/respiratory problem. (Remember that True only applies to you if you can not do something because of your lung/respiratory problem).

45. I cannot play sports or active games: True False
   (1) (2) intact1
46. I cannot go out for entertainment or recreation: True False
   (1) (2) intact2
47. I cannot go out of the house to do the grocery shopping: True False
   (1) (2) intact3
48. I cannot do household chores: True False
   (1) (2) intact4
49. I cannot move far from my bed or chair: True False
   (1) (2) intact5
50. Here is a list of other activities that your lung/respiratory problem may prevent you from doing. (You do not have to check these, they are just to remind you of ways in which your shortness of breath may affect you):
    Going for walks or walking the dog.
    Doing activities or chores at home or in the garden.
    Having sexual intercourse.
    Going to church, or a place of entertainment.
    Going out in bad weather or into smoky rooms.
    Visiting family or friends or playing with children.

Please write in any other important activities that your lung/respiratory problem may stop you from doing:

    a. 
    b. 
    c. 

51. Now, would you check (one only) which you think best describes how your breathing problem affects you.

    It does not stop me from doing anything I would like to do: (1 )
    It stops me from doing one or two things I would like to do: (2 )
    It stops me from doing most of the things I would like to do: (3 )
    It stops me from doing everything I would like to do: (4 )

Thank you for filling in this questionnaire. Before you finish, please check to see that you have answered all of the questions.
II. ADMINISTRATIVE MATTERS

1. General Comments: 

2. Research Coordinator:
   A. Signature: 
   B. LTRC Staff No. ___ ___ ___ - ___ ___ __

3. Date Form Completed: ___ ___ - ___ ___ - 2 ___ ___
   Month    Day    Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
ENVIRONMENTAL QUESTIONNAIRE

ID Number: 0 0
Letter Code: E Q 0
Form Type: 1

1. Date of Interview: ___ ___ ___ - ___ ___ - 2 ___ ___ ___
   Month     Day   Year

I. HOUSEHOLD CHARACTERISTICS

Now, I want to ask some questions about the house(s) you have lived in. As we talk about these conditions or exposures, please tell me if you have been exposed to these conditions and how long you were exposed to these conditions. We are looking for total exposure, so if you had an exposure for six months in one period and an exposure of eight months in another period, your total exposure would be for about one year. Respond to seasonal exposures as if they were for a full year even if the exposure was for a few months (e.g., swimming).

IF PARTICIPANT ANSWERS “NO” or “DON’T KNOW” to EXPOSURE, GO TO THE NEXT ACTIVITY.

<table>
<thead>
<tr>
<th>Exposure</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1. Have you ever used a wood or coal burning stove or fireplace with an open flame in your home?</td>
<td>heat1 (1)</td>
<td>(2)</td>
</tr>
<tr>
<td>2. I’m going to read you a list of devices. For each device, tell me if you ever used it in your home. If you did, tell me for how long you were exposed to it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Humidifier/Cool Mist Vaporizer</td>
<td>dev1 (1)</td>
<td>(2)</td>
</tr>
<tr>
<td>B. Sauna/Hot tub</td>
<td>dev2 (1)</td>
<td>(2)</td>
</tr>
</tbody>
</table>
3. Did your bathroom(s) or basement ever have visible mold or mildew on indoor surfaces?  

4. Please tell me if you, or anyone living in your house, ever had birds stay inside your home. Please tell me the number of years you’ve had them.

5. Please tell me if you ever used pillows with feathers or down and, if you did, for how long you used it.

II. SPECIFIC EXPOSURES CHART

Now I would like to ask some questions that deal with specific materials or substances that have been in the air (as dust, fumes, or vapor) in your jobs or in your hobbies, at work or at home. Wearing these metals in jewelry does not count as an exposure.

ASK ITEM A FOR EACH MATERIAL LISTED IN THE SPECIFIC EXPOSURES CHART:

A. Have you ever been exposed to (material/substance) as dust or fumes? IF NO OR DON'T KNOW, ASK EXPOSURE (ITEM A) ABOUT NEXT MATERIAL.

B. How long were you exposed to (material/substance)?

<table>
<thead>
<tr>
<th>Material</th>
<th>Exposure</th>
<th>(A) Yes</th>
<th>(A) No</th>
<th>(B) Don't Know</th>
<th>Number of Years</th>
<th>(B) Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beryllium</td>
<td>expos1</td>
<td>(1)</td>
<td>(2)</td>
<td>expos1yr</td>
<td>(3)</td>
<td>expos1dk</td>
</tr>
<tr>
<td>Cobalt</td>
<td>expos2</td>
<td>(1)</td>
<td>(2)</td>
<td>expos2yr</td>
<td>(3)</td>
<td>expos2dk</td>
</tr>
<tr>
<td>Asbestos</td>
<td>expos3</td>
<td>(1)</td>
<td>(2)</td>
<td>expos3yr</td>
<td>(3)</td>
<td>expos3dk</td>
</tr>
<tr>
<td>Silica</td>
<td>expos4</td>
<td>(1)</td>
<td>(2)</td>
<td>expos4yr</td>
<td>(3)</td>
<td>expos4dk</td>
</tr>
<tr>
<td>Arsenic</td>
<td>expos5</td>
<td>(1)</td>
<td>(2)</td>
<td>expos5yr</td>
<td>(3)</td>
<td>expos5dk</td>
</tr>
<tr>
<td>Cadmium</td>
<td>expos6</td>
<td>(1)</td>
<td>(2)</td>
<td>expos6yr</td>
<td>(3)</td>
<td>expos6dk</td>
</tr>
</tbody>
</table>
III. ADMINISTRATIVE MATTERS

1. General Comments: 

2. Research Coordinator:
   
   A. Signature: 

   B. LTRC Staff Number: ___ ___ ___ - ___ ___ ___ 

3. Date Form Completed: ___ ___ ___ - 2 ___ ___ 
   Month Day Year
1. **Date of Interview:**

   Month   Day   Year

   vis_dt

**I. ACTIVITIES ON THE JOB**

Now I would like to ask you some questions about specific job related activities. I will read slowly from a long list and ask you whether you have ever had a job — even if the job lasted less than six months — that involved any of the following activities. Please tell me if you have worked in any of them and how long, in years, you worked at the job. Please round fractions of years to the nearest whole number.

**IF PARTICIPANT ANSWERS “NO”, GO TO THE NEXT ACTIVITY.**

Ask each activity in turn and pause briefly for each activity. If patient does not answer, check NO and go to the next activity.
<table>
<thead>
<tr>
<th>A: Employment</th>
<th>B: Number of Years</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Aircraft/aerospace manufacturing
   - Yes: jobacm
   - No: jobalw
2. Animal laboratory worker
   - Yes: jobatwr
   - No: jobam
3. Auto or truck repair
   - Yes: jobbrb
   - No: jobcon
4. Automotive manufacturing
   - Yes: jobdb
   - No: jobeeew
5. Raising birds
   - Yes: jobcww
   - No: jobfl
6. Carpentry or woodworking
   - Yes: jobjn
   - No: jobob
7. Construction
   - Yes: jobob
   - No: joacy
8. Demolition of buildings
   - Yes: jobeeew
   - No: jobfl
9. Electrical or electronic worker
   - Yes: jobeew
   - No: jobob
10. Farming, ranching, farm laborer (wage laborer)
    - Yes: jobfl
    - No: jobob
11. Fire fighter
    - Yes: jobfl
    - No: jobob
12. In a sawmill
    - Yes: jobob
    - No: jobob
13. In a pulp mill
    - Yes: jobob
    - No: jobob
14. Hairdressing or cosmetology
    - Yes: jobob
    - No: jobob
15. Meat wrapping
    - Yes: jobob
    - No: jobob
16. Any type of mining
    - Yes: jobob
    - No: jobob
17. Dentist, dental product maker, or dental technician
    - Yes: jobob
    - No: jobob
18. In plant nursery or as a florist
    - Yes: jobob
    - No: jobob
19. Plastics manufacturing
    - Yes: jobob
    - No: jobob
20. Working with resins, polyurethane paints, or polyurethane foam manufacturing, or isocyanate paints
    - Yes: jobob
    - No: jobob
<table>
<thead>
<tr>
<th>ID Number:</th>
<th>0 0</th>
</tr>
</thead>
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<tr>
<td>Letter Code:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>Employment</th>
<th>Yes</th>
<th>No</th>
<th>B</th>
<th>Number of Years</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Pottery making or ceramics</td>
<td>jobpmc</td>
<td>(1)</td>
<td>jobpmcyr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Working in a quarry</td>
<td>jobqua</td>
<td>(1)</td>
<td>jobquayr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Sandblasting</td>
<td>jobsb</td>
<td>(1)</td>
<td>jobsbpyr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Smelting in a foundry</td>
<td>jobsf</td>
<td>(1)</td>
<td>jobsfyr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Stone cutting or polishing</td>
<td>jobscp</td>
<td>(1)</td>
<td>jobscpyr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Tunnel construction</td>
<td>jobtc</td>
<td>(1)</td>
<td>jobtcyr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Veterinarian/Veterinary work</td>
<td>jobvet</td>
<td>(1)</td>
<td>jobvetyr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Welding</td>
<td>jobwld</td>
<td>(1)</td>
<td>jobwldyr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Rubber factory worker</td>
<td>jobrfw</td>
<td>(1)</td>
<td>jobrfwyryr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>In a pet store</td>
<td>jobps</td>
<td>(1)</td>
<td>jobpsyr</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>In an occupation with radiation exposure</td>
<td>jobrde</td>
<td>(1)</td>
<td>jobrdeyr</td>
<td>(1)</td>
<td></td>
</tr>
</tbody>
</table>

**TELL RESPONDENT "THIS IS THE END OF THE LIST."**

32. In your office or indoor working environment, other than in the workplace bathrooms, have you ever noticed any of the following conditions: high humidity; water damage to furnishings, ceiling, tiles, or carpets; obvious mold or mildew not in a bathroom; or musty or moldy odors? IF YES, SPECIFY DURATION.

<table>
<thead>
<tr>
<th>(A)</th>
<th>Exposure</th>
<th>Yes</th>
<th>No</th>
<th>(B)</th>
<th>Number of Years</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>wrkenv</td>
<td>(A)</td>
<td>(B)</td>
<td></td>
<td>wrkenvyr</td>
<td>wrkenvdk</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>(1)</td>
<td>(1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>(2)</td>
<td>(2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. **ADMINISTRATIVE MATTERS**

1. General Comments: __________________________________________

2. Research Coordinator:
   A. Signature: __________________________________________
   B. LTRC Staff Number: __ __ __ - __ __ __

3. Date Form Completed: ___ ___ - ___ ___ - ___ __
   Month   Day    Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
SIX MINUTE WALK TEST

ID Number: 00 - - - - - - -
Letter Code: W T
Form Type: vis_dt

1. Date of Most Recent Test: ___ ___ - ___ ___ - 2 ___ ___  vis_dt
   Month Day Year

I. SIX MINUTE WALK TEST

1. Is the test performed as: LTRC Protocol Clinical Care
   (1) (2) smw_why

2. Is resting O₂ saturation at least 88% after appropriate O₂ titration? (1) (2)
   Yes No reso2sat
   ↓
   IF NO, GO TO PART II.

3. O₂ liter flow at rest: ___ ___ . ___ L/min reso2flo

4. Borg scale rating for perceived breathlessness at rest: ___ ___ ___ (1) rborgnd
   restbord Not Done

5. Borg scale rating for leg fatigue at rest: ___ ___ ___ (1) rlborgnd
   rstbordg Not Done

6. O₂ liter flow during exercise: ___ ___ . ___ L/min exo2flo

7. Total distance walked
   A. Distance ___ ___ ___ ___ distwalk
   B. Units Meters (1) distunit
      Feet (2)

8. O₂ saturation at termination: ___ ___ ___ % tero2sat

9. Borg scale rating for perceived breathlessness at termination? (1) tborgnd
   termborg Not Done

10. Borg scale rating for leg fatigue at termination? (1) tlborgnd
trmbordlg Not Done

11. Reason(s) for test termination check "test lasted six minutes"
   if test terminated at six minutes; otherwise check all that apply
   of items 10B - 10J.
   (1)
   A. Test lasted six minutes term6min
   B. Chest pain: termcp
   C. Near syncope: termsyn
   D. Ataxic gait: termatax
   E. Lower extremity claudication: termclau
   F. Mental confusion: termment
II. ADMINISTRATIVE MATTERS

1. General Comments: 

2. Six Minute Walk Tester:
   A. Signature: 
   B. LTRC Staff No. ___ ___ ___ - ___ ___ ___

3. Research Coordinator:
   A. Signature: 
   B. LTRC Staff No. ___ ___ ___ - ___ ___ ___

4. Date Form Completed: ___ ___ ___ - ___ ___ - ___ ___
   Month Day Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CARDIOPULMONARY EXERCISE TESTING FORM

ID Number: 00- - - - - - Letter Code: 
Form Type: CE01

1. Date of Examination: ____- ____- 2 ____  ____

1. PRELIMINARY TEST INFORMATION

   1. Is the test performed as:
      LTRC Protocol (1)
      Clinical Care (2)

   2. Best FEV₁: ____- ____ L

   3. Ramp Rate for exercise test:
      5 watts/min (1)
      10 watts/min (2)
      15 watts/min (3)

FEV₁ x 40 = MVV (L/min)
If MVV ≤ 40 L/min, then use ramp rate of 5 watts/min
If MVV > 40 L/min but < 80 L/min, then use ramp rate of 10 watts/min
If MVV ≥ 80 L/min, then use ramp rate of 15 watts/min
## CARDIOPULMONARY EXERCISE TEST

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<th>Quantity</th>
<th>A 5 Minute Rest</th>
<th>B 3 Minute Unloaded</th>
<th>C Maximum</th>
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<td>Yes (1)</td>
<td>No (2)</td>
<td>Yes (1)</td>
</tr>
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<td></td>
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<td>Yes (1)</td>
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Complete for LEVEL I and II Testing

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<td>cmp3munl</td>
<td>cmpmax</td>
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<table>
<thead>
<tr>
<th>Quantity</th>
<th>exerfic2</th>
<th>Room Air (0.21)</th>
<th>30% Oxygen (0.30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise F/O2</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<table>
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<tr>
<th>Quantity</th>
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<tbody>
<tr>
<td>Barometric Pressure (mmHg):</td>
<td>XXX</td>
<td>bapre0a</td>
<td>N/A</td>
</tr>
<tr>
<td>Equipment Deadspace (cc):</td>
<td>XXX</td>
<td>eqdedsna</td>
<td>N/A</td>
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<tr>
<td>SpO2 (%)</td>
<td>XXX</td>
<td>spo2a</td>
<td>spo2b</td>
</tr>
<tr>
<td>Ve (BTPS; L/min)</td>
<td>XXX.X</td>
<td>vebtpsna</td>
<td>vebtpsb</td>
</tr>
<tr>
<td>Vt (BTPS; L)</td>
<td>XXX</td>
<td>vbtpsna</td>
<td>vtbpsb</td>
</tr>
<tr>
<td>VO2 (STPD; L/min)</td>
<td>XXX.XXX</td>
<td>vo2stpdna</td>
<td>vo2stpdb</td>
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<tr>
<td>VCO2 (STPD; L/min)</td>
<td>XXX.XXX</td>
<td>vc02a</td>
<td>vc02b</td>
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<tr>
<td>Heart Rate (beats/minute)</td>
<td>XXX</td>
<td>hrstratea</td>
<td>hrstrateb</td>
</tr>
<tr>
<td>Respiratory Rate (breaths/minute)</td>
<td>XX</td>
<td>respa</td>
<td>respb</td>
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<td>Systolic blood pressure (mmHg)</td>
<td>XXX</td>
<td>sbpa</td>
<td>sbpb</td>
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<tr>
<td>Diastolic blood pressure (mmHg)</td>
<td>XXX</td>
<td>dbpa</td>
<td>dbpc</td>
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<td>Borg (breathlessness)</td>
<td>XX.X</td>
<td>borgbta</td>
<td>borgbttb</td>
</tr>
<tr>
<td>Borg (leg muscle fatigue)</td>
<td>XX.X</td>
<td>borglga</td>
<td>borg1gb</td>
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<tr>
<td>Load (watts)</td>
<td>XXX</td>
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Complete for LEVEL II Testing Only

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<td>pao2b</td>
<td>pao2c</td>
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<td>betco2a</td>
<td>betco2b</td>
<td>betco2c</td>
</tr>
<tr>
<td>pha</td>
<td>phb</td>
<td>phc</td>
</tr>
<tr>
<td>basexa</td>
<td>basexb</td>
<td>basexc</td>
</tr>
<tr>
<td>feco2a</td>
<td>feco2b</td>
<td>feco2c</td>
</tr>
</tbody>
</table>

22. Did the staff member terminate the test?  (Check all that apply)

If NO, go to Question 23.

Reason staff member terminated the test session. (Check all that apply)

A. Cadence dropped below 40 rpm and did not return
   - stcad
B. Mental confusion
   - stment
C. EKG arrhythmia
   - starrhy
D. EKG ischemia
   - stisch
E. Elevated blood pressure
   - stelbvp
F. Low blood pressure
   - stlowbp
G. Other
   - stothr
   - stoth_sp
23. Did the patient terminate the test?

Yes No
(1) (2)

ptterm

If NO, go to Part III.

Reason patient terminated the test session (Check all that apply):

A. Dyspnea or shortness of breath
B. Dizziness or lightheadedness
C. Chest pain
D. Leg fatigue
E. Other
   1) Specify ________________________________

III. ADMINISTRATIVE MATTERS

1. General Comments: ________________________________
   ________________________________

2. Cardiopulmonary Exercise Tester:
   A. Signature: ________________________________
   B. LTRC Staff Number: _______ _______ - _______ _______

3. Research Coordinator:
   A. Signature: ________________________________
   B. LTRC Staff Number: _______ _______ - _______ _______

4. Date Form Completed: _______ _______ - _______ - _______ 2
   Month Day Year

   compl_dt
LUNG TISSUE RESEARCH CONSORTIUM
PULMONARY FUNCTION TESTING

ID Number: 0 0 - 
Letter Code: 
Form Type: P F

1. Date of Study Visit:  _____ -  _____ - 2  -  _____  
   Month  Day  Year  

I. DEMOGRAPHIC INFORMATION

1. Height  _____ . ___ inches  
   A. Height is measured by: 
      Standing Height (1)  Arm Span (2)  
      htmeas  

2. Weight  _____  _____ pounds  

3. With which race or ethnicity do you identify?  
   (Check only one).  
   A. White (Caucasian) (1)  
   B. Hispanic (2)  
   C. African-American (whether Hispanic or not) (3)  
   D. Asian or Pacific Islander (4)  
   E. Native American (5)  
   F. Other, more than one, or none of the above (6)  

II. SPIROMETRY

1. Was the test: 
   Done at LTRC Center (1)  
   Done at Other Institution (2)  
   Not Done (3)  
   spir_wh

   If Spirometry not done, go to Part III.

   A. Date of Spirometry:  _____ -  _____ - 2  -  _____  
      Month  Day  Year  
      prbs_nd

2. Pre-Bronchodilator Spirometry not done (1)  
   IF PRE-BRONCHODILATOR SPIROMETRY NOT DONE, GO TO PART II, ITEM 4.

3. Pre-Bronchodilators

   A. FEV₁:  _____ -  _____ L  Not Done (1)  
      pre_fev1 prfevNd
   B. FVC:  _____ -  _____ L  Not Done (1)  
      pre_fvc prfvcNd
   C. FEV₆:  _____ -  _____ L  Not Done (1)  
      prfev6 prfev6nd
   D. PEFR:  _____ -  _____ L/Second  Not Done (1)  
      prpefr prpefrnd
4. Post-Bronchodilators

*Post-Bronchodilator Spirometry is required if the ratio of FEV₁ to vital capacity is less than 75% or the patient has a clinical indication other than ILD.

A. Post-Bronchodilator Spirometry not done: (1)

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<th>0 0</th>
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<th>P F</th>
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IF POST-BRONCHODILATOR SPIROMETRY NOT DONE, GO TO PART III.

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<th>vext_nd</th>
<th>fet100</th>
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<tr>
<td>B.</td>
<td>FEV₁:</td>
<td>_ _ _ L</td>
<td>Not Done</td>
<td>(1)</td>
<td>poev6 nd</td>
<td>poefr</td>
<td>vext Nd</td>
<td>fet100</td>
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<tr>
<td>C.</td>
<td>FVC:</td>
<td>_ _ _ _ L</td>
<td>Not Done</td>
<td>(1)</td>
<td>poev6 nd</td>
<td>poefr</td>
<td>vext Nd</td>
<td>fet100</td>
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<td>D.</td>
<td>FEV₆:</td>
<td>_ _ _ _ _ L</td>
<td>Not Done</td>
<td>(1)</td>
<td>poefr</td>
<td>vext Nd</td>
<td>fet100</td>
<td>fext100nd</td>
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<tr>
<td>E.</td>
<td>PEFR:</td>
<td>_ _ _ _ _ L/Second</td>
<td>Not Done</td>
<td>(1)</td>
<td>poefr</td>
<td>vext Nd</td>
<td>fet100</td>
<td>fext100nd</td>
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<tr>
<td>F.*</td>
<td>Vext:</td>
<td>_ _ _ _ _ _ L</td>
<td>Not Done</td>
<td>(1)</td>
<td>poefr</td>
<td>vext Nd</td>
<td>fet100</td>
<td>fext100nd</td>
</tr>
<tr>
<td>G.*</td>
<td>FET₁₀₀₀%:</td>
<td>_ _ _ _ _ Second</td>
<td>Not Done</td>
<td>(1)</td>
<td>poefr</td>
<td>vext Nd</td>
<td>fet100</td>
<td>fext100nd</td>
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* QC Items

III. LUNG VOLUME

A. Was the test: Done at LTRC Center (1)
   Done at Other Institution (2)
   Not Done (3)

IF LUNG VOLUME NOT DONE, GO TO PART IV

A. Date lung volume performed: __ __ __ - __ __ __ - __ __ __ Year

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<tr>
<th></th>
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<th>Helium Dilution</th>
<th>Nitrogen Washout</th>
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<tr>
<td>B.</td>
<td>Technique Plethysmography (1)</td>
<td>(2)</td>
<td>(3)</td>
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<td>C.</td>
<td>TLC:</td>
<td>_ _ _ _ _ _ _ _ L</td>
<td>Not Done</td>
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<tr>
<td>D.</td>
<td>Maximum SVC:</td>
<td>_ _ _ _ _ _ _ _ L</td>
<td>Not Done</td>
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<tr>
<td>E.</td>
<td>RV:</td>
<td>_ _ _ _ _ _ _ _ _ L</td>
<td>Not Done</td>
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<tr>
<td>F.</td>
<td>Mean FRC:</td>
<td>_ _ _ _ _ _ _ _ L</td>
<td>Not Done</td>
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<tr>
<td>G.</td>
<td>Raw-insp</td>
<td>_ _ _ _ _ _ _ _ _ cm H₂O/Liters/Sec</td>
<td>Not Done</td>
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<tr>
<td>H.</td>
<td>sGaw-insp</td>
<td>_ _ _ _ _ _ _ _ _ L/cm H₂O/Sec/Liter</td>
<td>Not Done</td>
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<td></td>
</tr>
<tr>
<td>H.</td>
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</table>
IV. DIFFUSING CAPACITY (DlCO)

1. Was the test:  
   Done at LTRC Center (1)  
   Done at Other Institution (2)  
   Not Done (3)  

   **IF DlCO NOT DONE, GO TO PART V.**

   A. Date DlCO performed: ___ ___ - ___ ___ - 2 __ year  
      mndlco  

   2. Mean DlCO (uncorrected for hemoglobin)  
      ___ ___ . ___ ml/min/mmHg  
      Not Done (1)  
      mndlco  

   3. Vi:  
      ___ ___ L  
      Not Done (1)  
      vi nd  

   4. VAlv  
      ___ ___ L  
      Not Done (1)  
      valv nd  

V. ROOM AIR ARTERIAL BLOOD GAS ANALYSIS (ABG)

1. Was the test:  
   Done at LTRC Center (1)  
   Done at Other Institution (2)  
   Not Done (3)  

   **IF ABG NOT DONE, GO TO PART VI.**

   A. Date of arterial blood draw: ___ ___ - ___ ___ - 2 __ year  
      pac2  

   2. PaO2  
      ___ ___ mmHg  
      Not Done (1)  
      pac2 nd  

   3. PaCO2  
      ___ ___ mmHg  
      Not Done (1)  
      paco2 nd  

   4. pH:  
      ___ ___  
      Not Done (1)  
      ph nd  

   5. O2 Sat:  
      ___ ___ . ___ %  
      Not Done (1)  
      o2sat nd  

   6. COHb:  
      ___ ___ gm %  
      Not Done (1)  
      cohb nd
VI. ADMINISTRATIVE MATTERS

1. General Comments: 

2. PFT Tester:
   A. Signature: 
   B. LTRC Staff No. 

3. Research Coordinator:
   A. Signature: 
   B. LTRC Staff No. 

4. Date form completed: ___-___-___
   Month   Day   Year
LUNG TISSUE RESEARCH CONSORTIUM
LABORATORY DATA FORM

ID Number: 0 0 - Letter Code: L
Form Type: D

1. Date of Examination: ________ - ________ - 2 ________
   Month   Day   Year

   vis_dt

I. BLOOD TESTS

   Complete Question 1 for all patients.

   1. CBC

      A. Date of CBC: ________ - ________ - 2 ________
         Month   Day   Year
         cbc_dt   cbc_nd
      (1)
      Not Done

   IF CBC NOT DONE GO TO QUESTION 2.

      B. WBC: ________ . ___ X 10^9/L  Not Done (1)
         wbc    wbc_nd
      Not Done (1)
      diff_nd

      C. WBC Differential:

         1. neutrophilic ________ . ___ %
            wbcdiff1
         2. lymphocytes  ________ . ___ %
            wbcdiff2
         3. monocytes  ________ . ___ %
            wbcdiff3
         4. eosinophils  ________ . ___ %
            wbcdiff4
         5. basophils  ________ . ___ %
            wbcdiff5

      D. Hgb: ________ . ___ g/dL  Not Done (1)
         hgb    hgb_nd
      Not Done (1)
      hemctnt

      E. Hematocrit:  ________ . ___ %
         hemctnt    hemctnt
      Not Done (1)
      plat_nd

      F. Platelets: ________ . ___ X 10^9/L  Not Done (1)
         platlet    platlet

2. LAB CHEMISTRIES

   Complete Question 2 if a patient has a clinical indication of ILD. Abstract for non-ILD patient if available.

   A. Date of Lab Chemistries: ________ - ________ - 2 ________
      Month   Day   Year
      labch_dt   labch_nd
   (1) Not Done

   IF Not Done go to Question 3.

   B. Rheumatoid Factor (RF):  Present  Absent  Not Done (3)
      (1)  (2)  ck_nd

   C. Creatine Kinase (CK): ________ . ___ U/L  Not Done (1)
      ck

   D. Erythrocyte Sedimentation Rate (ESR): ________ . ___ mm/hr  Not Done (1)
      esr ehr Nd
### E. Anti-Nuclear Antibody (ANA):
- Positive (1)
- Negative (2)
- Not Done (3)

### F. Antibodies to double stranded DNA (Anti-dsDNA)
- Present (1)
- Absent (2)
- Not Done (3)

### G. Jo-1 Antigen
- Positive (1)
- Negative (2)
- Not Done (3)

### H. Antibodies to SCL-70
- (1)
- (2)
- (3)

### I. Antibodies to SS-A
- (1)
- (2)
- (3)

### J. Antibodies to SS-B
- (1)
- (2)
- (3)

### K. Anti-centromere Antibodies
- (1)
- (2)
- (3)

### L. Extractable Nuclear Antigen (ENA)
- (1)
- (2)
- (3)

### III. ADMINISTRATIVE MATTERS

#### 1. General Comments:

#### 2. Research Coordinator:
- Signature:

#### 3. Date Form Completed:
- Month: ___
- Day: ___
- Year: ___
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
TISSUE COLLECTION MAILING FORM

ID Number: 0 0 ___________ 0 0 0 0
Letter Code: ___________
Form Type: T C 0 1

The Collection Time is the time when the tissue is first excised from the lung.

1. A. Collection Date of tissue specimens: _______ - _______ - _______ Month Day Year
   B. Collection Time of tissue specimens: _______ : _______ Hr Min

I. SHIPPING INFORMATION

This mailing form must be completed for each tissue specimen that is collected to be shipped to LTRC at the University of Colorado HSC. A shipping list to be sent with the tissue will be generated when data entry of this form is complete.

1. Tissue ID Number (affix barcode label here): __________________________

2. Type of tissue submitted for this case: (check one)
   - Lung explant, single (1)
   - Lung explant, bilateral (2)
   - Lung lobectomy/wedge resection (3)
   - Lung biopsy (4)
   - LVRS (5)

3. Lobes sampled, check all that apply:
   A. Left Upper (1) samplu
   B. Lingula (1) samplg
   C. Left Lower (1) sampll
   D. Right Upper (1) sampru
   E. Right Middle (1) samprm
   F. Right Lower (1) samprl
The Fixative Completion Time is the time when the last specimen is fixed/frozen.

4. A. Fixative Completion Date: __________ - ________ - 2 ______
   Month    Day    Year

   B. Fixative Completion Time: fixtm_hr : fixtm_mn
   Hr      Min

5. Specimens submitted:

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<tr>
<th>Option</th>
<th># of Containers with Tissue Shipped to TCL*</th>
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<tbody>
<tr>
<td>A. Freezing suture line(s) (8 ml tube, biopsy only)</td>
<td>tspec_a</td>
</tr>
<tr>
<td>B. Formalin-fixed, strips (100 ml specimen containers)</td>
<td>tspec_b</td>
</tr>
<tr>
<td>C. HOPE-fixed (25 ml tubes for biopsy, 70 ml tubes for explant)</td>
<td>tspec_c</td>
</tr>
<tr>
<td>D. RNAlater (25 ml tubes for biopsy, 70 ml tubes for explant)</td>
<td>tspec_d</td>
</tr>
<tr>
<td>E. Flash frozen (25 ml tubes, biopsy only)</td>
<td>tspec_e</td>
</tr>
<tr>
<td>F. Flash frozen - 2.0 x 0.5 x length of lobe-strips (explant only)</td>
<td>tspec_f</td>
</tr>
<tr>
<td>G. Glutaraldehyde (8 ml tubes, Mayo UCHSC only)</td>
<td>tspec_g</td>
</tr>
</tbody>
</table>

* Please return all containers to TCL regardless of whether they contain tissue or not.

6. Date samples shipped to TCL: __________ - ________ - 2 ______
   Month    Day    Year

II. ADMINISTRATIVE MATTERS

1. General Comments: _______________________________________________________

2. Shipped by:
   A. Signature: __________________________________________________________

   B. Telephone Number: (_______) ________ - ________

   C. LTRC Staff No. ________ - ________

3. Date Form Completed: __________ - ________ - 2 ______
   Month    Day    Year

CALL TCL AT (303) 315-5475 TO NOTIFY THEM THAT A SHIPMENT WILL BE SENT VIA FEDEX OR UPS AND PROVIDE THEM WITH THE TRACKING NUMBER(S). SHIP ONLY ON MONDAY TUESDAY, OR WEDNESDAY. DO NOT SEND THIS FORM TO THE TCL.
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
BLOOD COLLECTION MAILING FORM

ID Number: 0 0 - ________ - ______ - ________
Letter Code: B C
Form Type: 

1. Collection Date of Blood Specimen: ______ - ______ - 2 _______
   Month      Day     Year

I. SHIPPING INFORMATION:

THIS MAILING FORM MUST BE COMPLETED FOR EACH BLOOD SPECIMEN THAT IS COLLECTED TO BE
SHIPPED TO THE LTRC AT THE UNIVERSITY OF COLORADO HSC. A SHIPPING LIST TO BE SENT WITH THE
BLOOD WILL BE GENERATED WHEN DATA ENTRY OF THIS FORM IS COMPLETE.

1. Blood ID Number (affix barcode label here): ___________________________

2. Specimens submitted: 
   # of Containers with 
   Blood Specimens 
   Submitted to TCL*
   A. Blood (Red/Gray Tigertop) bldspec1
   B. Blood (Gray/Green Tigertop) bldspec2
   C. Blood (Blue Top) bldspec3

*Please return all containers to the TCL regardless of whether or not they contain blood specimens.

3. Date samples shipped to TCL: ______ - ______ - 2 _______
   Month      Day     Year

II. ADMINISTRATIVE MATTERS

1. General Comments: ____________________________________________

2. Shipped by:
   A. Signature: ____________________________________________
   B. Telephone Number: (______) ____-_______
   C. LTRC Staff Number: ____-____

3. Date form completed: ______ - ______ - 2 _______
   Month      Day     Year

CALL TCL AT (303) 315-5475 TO NOTIFY THEM THAT A SHIPMENT WILL BE SENT VIA FEDEX OR
UPS AND PROVIDE THEM WITH THE TRACKING NUMBER(S). SHIP ONLY ON MONDAY,
TUESDAY, OR WEDNESDAY. DO NOT SEND THIS FORM TO THE TCL.
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CT SHIPPING RECORD

ID Number: 0 0 -  -  -  -  -  -  -
Letter Code: 
Form Type: C S

1. Date of CT Scan Acquisition: ____ ____ ____ - ____ ____ - 2 ____ ____ vis_dt
   Month   Day   Year

I. SHIPPING INFORMATION

This shipping record must be completed for each CT scan that is collected. A
manifest list to be sent with the CT scan to the Mayo Clinic will be generated
when data entry of this form is complete.

1. CT Technologist Input:
   A. Scanner Protocol:
      LTRC Full Three-Phase Protocol (1)
      Basic LTRC High-Resolution CT (2)
      Retrospective CT obtained at Clinical Center (3)
      Retrospective CT from Outside Media (CD etc.) (4)

B. Series Number
      1 2 3 4 5 6 7 8

C. Number of Images

2. Radiologist Input:
   A. Date of CT Scan Interpretation: ____ ____ ____ - ____ ____ - 2 ____ ____ scan_dt
      Month   Day   Year

3. Study Coordinator Input:
   A. CT Number
      (Affix CT label here): ______________________________ ctnum

B. Method of Transfer: Electronic Media (1) transmeth
       (2)

C. Date of CT Transfer: ____ ____ ____ - ____ ____ - 2 ____ ____ ctnrn_dt
       Month   Day   Year

D. Shipped by: ___________________________________________ ctshpnam

E. Date of shipment: ____ ____ ____ - ____ ____ - 2 ____ ____ ctshp_dt
       Month   Day   Year
II. ADMINISTRATIVE MATTERS

1. General Comments: 

2. CT Technologist:
   A. Name: 
   B. LTRC Staff Number: 

3. Study Coordinator:
   A. Signature: 
   B. LTRC Staff Number: 

4. Date form completed: 

Use only a postage-paid pre-addressed envelope and packaging label supplied by the RCL. If you encounter any problems, please contact either of the following:

Julie Buenger
Phone: (507) 266-3575
Fax: (507) 538-7076

Kathleen Mieras
Phone: (507) 284-9187
Fax: (507) 538-0593

Do not send this form to the RCL
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CT SCAN REPORT

CT Number: ____________ Form Type: S R 0 1

1. Date of Report: ____________ - ____________ - 2 ____________
   Month      Day        Year

I. QUANTITATIVE IMAGE ANALYSIS RESULTS

1. CT Acceptable for Quantitative Analysis
   (1) (2)  
   Yes    No
   If NO, then specify reason:
   (1) Apparently not Full 3-Phase LTRC Protocol
   (2) Other (Specify):

   If CT not acceptable for quantitative analysis, go to Part II.

2. 3D Image analysis results
   Not Done
   (1)  
   If 3D Analysis not done, then go to Part II.
   Yes    No
   A. Histogram analysis
   B. Texture analysis
   C. Bronchial branching analysis

3. Date of Analysis: ____________ - ____________ - 2 ____________
   Month      Day        Year

4. CT Analyst Name: ____________________________

5. LTRC Staff No.: ____________________________

II. QUALITATIVE IMAGE ASSESSMENT AND DESCRIPTION

1. CT Study Verification and Image Quality

<table>
<thead>
<tr>
<th>A. Series Number</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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<tr>
<td>B. Description*</td>
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<td>C. Image Count</td>
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<tr>
<td>D. Image Quality Assessment**</td>
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<tr>
<td>E. QA Problem Type***</td>
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*Description Popup Selections: 1) Scout, 2) Inspiration Supine LTRC volumetric scan, 3) Expiration Supine LTRC volumetric scan, 4) Inspiration Prone LTRC volumetric scan, 5) Inspiration HRCT, 6) Expiration HRCT, 7) Prone HRCT, 8) Other Chest CT, 9) Other CT (non-chest scan), 10) Other Chest CT and other CT (non-chest scan), 11) Image Not Viewable, 12) Other Non-CT Scan Data

** Image Quality Selections: 1) Optimal, 2) Good, 3) Fair, 4) Poor, 5) Not Assessable

*** QA Problem Types: 1) Respiratory Motion Artifact, 2) Other Patient Motion Artifact, 3) Grainy/Noisy Images 4) Incorrect LTRC protocol parameters, 5) Other Scanner Artifacts
### Specific Regional Findings

<table>
<thead>
<tr>
<th>LUNG Lobe Regional Distribution</th>
<th>Upper a (1)</th>
<th>Middle b (2)</th>
<th>Lower c (1)</th>
<th>Upper X-Lingula a (1)</th>
<th>Lingula b (2)</th>
<th>Lower c (1)</th>
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<tbody>
<tr>
<td>A. Air Trapping</td>
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<td>E. Consolidation</td>
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<td>I. Honeycombing</td>
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<tr>
<td>J. Micronodules (&lt;5 mm)</td>
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<td>K. Mosaic Attenuation</td>
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<td>L. Pulmonary Cysts</td>
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<td>M. Reticular Infiltrates</td>
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<tr>
<td>O. Tree in Bud Pattern</td>
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</tr>
</tbody>
</table>

**Fill in with numbers:**
- 0 - Normal/None
- 1 - Mild (1-25% involvement)
- 2 - Moderate (26-50% involvement)
- 3 - Marked (50-75% involvement)
- 4 - Severe (>75% involvement)
- 6 - Region cannot be evaluated / no data available
3. Ancillary Findings (Check if present)

<table>
<thead>
<tr>
<th>A. Evidence for prior Thoracic Surgery (Not CABG)</th>
<th>(1) Right</th>
<th>(2) Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Pulmonary Nodules or Masses (&gt;10mm)</td>
<td>prsurgR</td>
<td>prsurgL</td>
</tr>
<tr>
<td>C. Parenchymal Bands</td>
<td>pnbdr</td>
<td></td>
</tr>
<tr>
<td>D. Giant Bulla (at least 1/3 volume of the lungs)</td>
<td>gbullar</td>
<td></td>
</tr>
<tr>
<td>E. Pulmonary Cavities (thick walled)</td>
<td>pucavR</td>
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</tr>
<tr>
<td>F. Lobar or segmental collapse</td>
<td>lobcolR</td>
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</tr>
<tr>
<td>G. Mediastinal/Hilar Mass/Adenopathy</td>
<td>medmasR</td>
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</tr>
<tr>
<td>H. Enlarged Pulmonary Arteries</td>
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</tr>
<tr>
<td>I. Pleural Thickening</td>
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<tr>
<td>J. Pleural Effusion</td>
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<tr>
<td>K. Pleural Calcifications</td>
<td>pleucaR</td>
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</tr>
<tr>
<td>L. Skeletal Deformity (scoliosis, kyphosis, compression fractures)</td>
<td>skdefR</td>
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<tr>
<td>M. Other/Comments (e.g. esophageal dilatation, microlithiasis, etc. ...specify)</td>
<td>ctooth_sp</td>
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Specify: __________________________________________

<table>
<thead>
<tr>
<th>N. Nodules</th>
<th>(1) Right Image Number(s)</th>
<th>(2) Left Image Number(s)</th>
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<tr>
<td>nodL_sp</td>
<td>nodL_sp</td>
<td></td>
</tr>
</tbody>
</table>

4. Radiologist Summary Descriptions:

A. Best description of axial distribution of emphysema

(1) None
(2) Peripheral/Subpleural
(3) Central/Axial
(4) Evenly Distributed

B. Best description of craniocaudal distribution of emphysema

(1) None
(2) Upper lung predominant
(3) Lower lung predominant
(4) Diffuse
(5) Superior segments of lower lobes predominantly involved

C. Best description of axial distribution of interstitial process

(1) None
(2) Peripheral/Subpleural
(3) Central/Axial
(4) Evenly distributed

D. Best description of craniocaudal distribution of interstitial process

(1) None
(2) Upper lung predominant
(3) Lower lung predominant
(4) Diffuse
5. Radiologist Diagnosis

<table>
<thead>
<tr>
<th>A. Primary</th>
<th>B. Secondary</th>
<th>C. Secondary</th>
<th>D. Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>ctdiag1</td>
<td>ctdiag2</td>
<td>ctdiag3</td>
<td>ctdiag4</td>
</tr>
</tbody>
</table>

Please fill in a primary diagnosis and up to 3 secondary diagnoses from the Diagnosis List.

<table>
<thead>
<tr>
<th>Diagnosis List</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Centrilobular Emphysema</td>
</tr>
<tr>
<td>(2) Panlobular Emphysema</td>
</tr>
<tr>
<td>(3) Paraseptal Emphysema</td>
</tr>
<tr>
<td>(4) Idiopathic Pulmonary Fibrosis/Usual Interstitial Pneumonia</td>
</tr>
<tr>
<td>(5) Nonspecific Interstitial Pneumonia</td>
</tr>
<tr>
<td>(6) Desquamative Interstitial Pneumonia</td>
</tr>
<tr>
<td>(7) Respiratory Bronchiolitis</td>
</tr>
<tr>
<td>(8) Respiratory Bronchiolitis-Associated Interstitial Lung Disease</td>
</tr>
<tr>
<td>(9) Lymphocytic Interstitial Pneumonitis</td>
</tr>
<tr>
<td>(10) Cryptogenic Organizing Pneumonia / Bronchiolitis Obliterans Organizing Pneumonia</td>
</tr>
<tr>
<td>(11) Acute Interstitial Pneumonia / Diffuse Alveolar Damage</td>
</tr>
<tr>
<td>(12) Non-Diagnostic</td>
</tr>
<tr>
<td>(13) Fibrosis-Uncharacterized</td>
</tr>
<tr>
<td>(14) Primary Bronchogenic Carcinoma</td>
</tr>
<tr>
<td>(15) Lymphoma</td>
</tr>
<tr>
<td>(16) Pulmonary Metastases</td>
</tr>
<tr>
<td>(17) Sarcoidosis</td>
</tr>
<tr>
<td>(18) Berylliosis</td>
</tr>
<tr>
<td>(19) Hypersensitivity Pneumonitis (Acute/Cellular)</td>
</tr>
<tr>
<td>(20) Hypersensitivity Pneumonitis (Chronic/Fibrotic)</td>
</tr>
<tr>
<td>(21) Autoimmune Disease: Connective Tissue-related</td>
</tr>
<tr>
<td>(Scleroderma/SLE/Sjogren/PM/DM/MCTD/UCTD)</td>
</tr>
<tr>
<td>(22) Bronchiolitis Obliterans / Bronchiolitis</td>
</tr>
<tr>
<td>(23) Vasculitis /Capillaritis / Wegener’s Granulomatosis</td>
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<tr>
<td>(24) Eosinophilic Granuloma / Langerhans’ Cell Granulomatosis / EC</td>
</tr>
<tr>
<td>(25) Eosinophilic Pneumonia</td>
</tr>
<tr>
<td>(26) Granulomatous Infection: Mycobacterium Tuberculosis</td>
</tr>
<tr>
<td>(27) Granulomatous Infection: Atypical Mycobacterium / MAI / etc.</td>
</tr>
<tr>
<td>(28) Granulomatous Infection: Fungi</td>
</tr>
<tr>
<td>(29) Granulomatous Inflammation Not Otherwise Specified (NOS)</td>
</tr>
<tr>
<td>(30) Normal</td>
</tr>
<tr>
<td>(50) Other</td>
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</tbody>
</table>

Specify: A. ICD-9 
B. ICD-9 
C. ICD-9 
D. ICD-9 

---

caiglsp diag2sp diag3sp diag4sp
III. ADMINISTRATIVE MATTERS

1. General Comments: ________________________________
   ________________________________
   gen_cmnt

2. Core Lab Radiologist:
   A. Signature: ________________________________
   cert_sig
   B. LTRC Staff No.: _______ ______ - ______
   cert_no

3. Date form completed: _______ - ______ - 2 ______
   Month  Day  Year
   compl_dt
II. **QUALITATIVE IMAGE ASSESSMENT AND DESCRIPTION**

1. **CT Study Verification and Image Quality**

† Sequential number should be entered into the cells starting with 9.

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<tr>
<th>Sequential Number †</th>
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<tr>
<td>B. Description*</td>
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<td>C. Image Count</td>
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<tr>
<td>D. Image Quality Assessment**</td>
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<td>E. QA Problem Type***</td>
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</tbody>
</table>

*Description Popup Selections: 1) Scout, 2) Inspiration Supine LTRC volumetric scan, 3) Expiration Supine LTRC volumetric scan, 4) Inspiration Prone LTRC volumetric scan, 5) Inspiration HRCT, 6) Expiration HRCT, 7) Prone HRCT, 8) Other Chest CT, 9) Other CT (non-chest scan), 10) Other Chest CT and other CT (non-chest scan), 11) Image Not Viewable, 12) Other Non-CT Scan Data

** Image Quality Selections: 1) Optimal, 2) Good, 3) Fair, 4) Poor, 5) Not Assessable

*** QA Problem Types: 1) Respiratory Motion Artifact, 2) Other Patient Motion Artifact, 3) Grainy/Noisy Images 4) Incorrect LTRC protocol parameters, 5) Other Scanner Artifacts
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CENTRAL PATHOLOGY REPORT

Specimen Number:  
Form Type: C P 0 1

1. Date specimen obtained: ______-______-__ 2 __  
   Month     Day      Year
I. EVALUATION

1. Final pathologic diagnosis:

<table>
<thead>
<tr>
<th></th>
<th>Primary</th>
<th>Secondary</th>
<th>Secondary</th>
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<tbody>
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<td>Left Lower</td>
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Please select 1 primary diagnosis and up to 3 secondary diagnoses. Fill in with the following LTRC codes or if “Other” code, specify the ICD-9 code in format xxx.xx:

1. Emphysema, centrilobular
2. Emphysema, panlobular
3. Emphysema, paraseptal
4. Usual interstitial pneumonia (UIP)
5. Non-specific interstitial pneumonia (NSIP)
6. Desquamative interstitial pneumonia (DIP)
7. Respiratory bronchiolitis (RB)
8. Respiratory bronchiolitis-interstitial lung disease (RB-ILD)
9. Lymphocytic interstitial pneumonia (LIP)
10. Organizing Pneumonia (OP)
11. Diffuse Alveolar Damage (DAD)
12. Non-Diagnostic
13. Fibrosis-Uncharacterized
14. Honeycomb Lung
15. Carcinoma, non-small cell
16. Carcinoma, small cell
17. Lymphoma
18. Sarcoma
19. Sarcoïd
20. Berylliosis
21. Hypersensitivity Pneumonitis (Cellular)
22. Hypersensitivity Pneumonitis (Fibrotic)
23. Bronchiolitis (Constrictive)
24. Bronchiolitis (Proliferative)
25. Bronchiolitis (Cellular)
26. Bronchiolitis (Diffuse panbronchiolitis)
27. Bronchiolitis (Neuroendocrine Cell Hyperplasia)
28. Vasculitis/Capillaritis
29. Eosinophilic Granuloma (EG, LCG)
30. Eosinophilic Pneumonia
31. Granulomatous Infection (M Tuberculosis)
32. Granulomatous Infection (Atypical Tuberculosis (MAI))
33. Granulomatous Infection (Fungi)
34. Granulomatous Inflammation (NOS)
35. Normal
50. Other
II. ADMINISTRATIVE MATTERS

1. General Comments:  

2. Core Lab Pathologist:  
   A. Signature:  
   B. LTRC Staff No. ____ ____ ____ - ____ ____  

3. Date Form Completed: ____ ____ ____ - ____ ____ - 2 ____ ____  
   Month  Day  Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
LOCAL PATHOLOGY REPORT

| ID Number: | 0 0 | - | - | - |
| Letter Code: | | | |
| Form Type: | L P 0 1 |

1. Date specimen obtained: 

    ___ ___ - ___ ___ - ___ ___
    Month   Day   Year
## EVALUATION

### 1. Final Pathologic Diagnosis

Please select 1 primary diagnosis and up to 3 secondary diagnoses. Fill in with the following numbers:

- (1) Emphysema, centrilobular
- (2) Emphysema, panlobular
- (3) Emphysema, paraseptal
- (4) Usual interstitial pneumonia (UIP)
- (5) Non-specific interstitial pneumonia (NSIP)
- (6) Desquamative interstitial pneumonia (DIP)
- (7) Respiratory bronchiolitis (RB)
- (8) Respiratory bronchiolitis-interstitial lung disease (RB-ILD)
- (9) Lymphocytic interstitial pneumonia (LIP)
- (10) Organizing Pneumonia (OP)
- (11) Diffuse Alveolar Damage (DAD)
- (12) Non-Diagnostic
- (13) Fibrosis-Uncharacterized
- (14) Honeycomb Lung
- (15) Carcinoma, non-small cell
- (16) Carcinoma, small cell
- (17) Lymphoma
- (18) Sarcoma
- (19) Sarcoid
- (20) Berylliosis
- (21) Hypersensitivity Pneumonitis (Cellular)
- (22) Hypersensitivity Pneumonitis (Fibrotic)
- (23) Bronchiolitis (Constrictive)
- (24) Bronchiolitis (Proliferative)
- (25) Bronchiolitis (Cellular)
- (26) Bronchiolitis (Diffuse panbronchiolitis)
- (27) Bronchiolitis (Neuroendocrine Cell Hyperplasia)
- (28) Vasculitis/Capillaritis
- (29) Eosinophilic Granuloma (EG, LCG)
- (30) Eosinophilic Pneumonia
- (31) Granulomatous Infection (M Tuberculosis)
- (32) Granulomatous Infection (Atypical Tuberculosis (MAI))
- (33) Granulomatous Infection (Fungi)
- (34) Granulomatous Inflammation (NOS)
- (35) Normal
- (36) Other

Specify:

- **A.** ICD-9
- **B.** ICD-9
- **C.** ICD-9
- **D.** ICD-9
II. ADMINISTRATIVE MATTERS

1. General Comments: 
   ____________________________________________________________
   ____________________________________________________________

2. Site Pathologist/Principal Investigator or Co-Investigator:
   A. Signature: ________________________________________________
   B. LTRC Staff No. ___ ___ ___ - ___ ___ ___

3. Research Coordinator:
   A. Signature: ________________________________________________
   B. LTRC Staff No. ___ ___ ___ - ___ ___ ___

4. Date Form Completed: ___ ___ ___ - ___ ___ - 2 ___ ___ ___
   Month   Day   Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)  
CLINICAL DIAGNOSIS REPORT

<table>
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1. Date of final diagnosis: ___ ___ - ___ ___ - ___ ___  
   Month Day Year  
   **vis_dt**
I. EVALUATION

<table>
<thead>
<tr>
<th></th>
<th>A. Primary</th>
<th>B. Secondary</th>
<th>C. Secondary</th>
<th>D. Secondary</th>
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<td>Final Clinical Diagnosis</td>
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<td>cldiag2</td>
<td>cldiag3</td>
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</table>

Please select 1 primary diagnosis and up to 3 secondary diagnoses. Fill in with the following numbers:

1. Emphysema
2. Idiopathic pulmonary fibrosis (Idiopathic UIP)
3. NSIP
4. Desquamative interstitial pneumonia (DIP)
5. Respiratory bronchiolitis (RB)
6. Respiratory bronchiolitis-interstitial lung disease (RB-ILD)
7. Lymphocytic interstitial pneumonia (LIP)
8. Cryptogenic Organizing Pneumonia (COP)
9. Acute interstitial pneumonia (AIP)
10. Fibrosis-Uncharacterized
11. Carcinoma, non-small cell
12. Carcinoma, small cell
13. Lymphoma
14. Sarcoid
15. Berylliosis
16. Hypersensitivity Pneumonitis
17. Autoimmune Disease (SLE)
18. Autoimmune Disease (Sjogren)
19. Autoimmune Disease (RA)
20. Autoimmune Disease (Scleroderma)
21. Autoimmune Disease (PM/DM)
22. Autoimmune Disease (MCTD)
23. Autoimmune Disease (UCTD)
24. Bronchiolitis (Constrictive)
25. Bronchiolitis (Proliferative)
26. Bronchiolitis (Cellular)
27. Bronchiolitis (Diffuse panbronchiolitis)
28. Bronchiolitis (Neuroendocrine Cell Hyperplasia)
29. Vasculitis/Capillaritis
30. Eosinophilic Granuloma (EG, LCG)
31. Eosinophilic Pneumonia
32. Granulomatous Infection (M Tuberculosis)
33. Granulomatous Infection (Atypical Tuberculosis (MAI))
34. Granulomatous Infection (Fungi)
35. Granulomatous Inflammation (NOS)
36. Normal
37. Other

A. ICD-9: diag1sp

B. ICD-9: diag2sp

C. ICD-9: diag3sp

D. ICD-9: diag4sp
II. ADMINISTRATIVE MATTERS

1. General Comments: 

____________________________________________________________________

____________________________________________________________________

2. Principal or Co-Investigator:
   A. Signature: 

   ___________________________________________________________________

   B. LTRC Staff Number: ___ ___ - ___ ___

3. Research Coordinator:
   A. Signature: 

   ___________________________________________________________________

   B. LTRC Staff Number: ___ ___ - ___ ___

4. Date form completed: 

   ___ ___ - ___ ___ - ___ ___

   Month    Day    Year

Not

Yes    No    Necessary

(1)    (2)    (3)  notifymd

gen_cmnt

pi62_sig

pi62_no

cert_sig

cert_no

compl_dt
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
ADVERSE EVENT REPORT FORM

I. ADVERSE EVENT INFORMATION

1. A. Onset Date: __________ - __________ - 2 __________
   Month    Day    Year

2. A. End Date: __________ - __________ - 2 __________
   Month    Day    Year

3. Adverse Event Description: ____________________________

4. Body System(s) Affected
   A. Neurological (1) (2) aeneuro
   B. Cardiovascular (1) (2) aecard
   C. Reticuloendothelial (1) (2) aerepen
d
   E. Digestive (1) (2) aediges
   F. Musculoskeletal (1) (2) aemusc
   G. Immunology (1) (2) aemun
   H. Skin (1) (2) aeskin
   I. Urogenital (1) (2) aeurogen
   J. ENT (1) (2) aent
   K. Metabolic (1) (2) aematab
   L. Nutritional (1) (2) aenutr
   M. Endocrine (1) (2) aeendo
   N. Other: (1) (2) aeothr

   Specify ____________________

5. Category of Event: Expected (1) aecateg
   Not Expected (2)

6. Outcome: Resolved (1) aeoutcm
   Ongoing (2)
   Died (3)
7. Severity of Event: Light (1)
   Moderate (2)
   Severe (3)

8. Relationship to LTRC Protocol: Not Related (1)
   Unlikely (2)
   Possibly (3)
   Probably (4)
   Definitely (5)

II. ADMINISTRATIVE MATTERS

1. General Comments: ______________________________________________________

2. Principal or Co-Investigator (Signature required for SAE's only):
   A. Signature: ____________________________________________________________

3. Research Coordinator:
   A. Signature: __________________________________________________________
   B. LTRC Staff No. _______ _______ - _______ _______

4. Date Form Completed: _______ _______ - _______ - _______ ______
   Month     Day     2     Year