LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
SUBJECT SCREENING FORM

ID Number: 0 0 - 
Letter Code: 
Visit Number: 0 1

1. Date subject was enrolled: vis_dt
   -  - 0 1 
     Month Day Year

I. SCREENING INFORMATION

1. Has the patient previously enrolled in the LTRC? prvenrl
   Yes (1) No (2)

   IF NO, go to question 2.

   A. Date subject was last enrolled: prve_dt
      -  - 0 1 
        Month Day Year

   B. Previous ID number in the LTRC: prv_id
      _ _0 _ __ - __ __ __ __ - __

2. Inclusion criteria:

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

   B. Does the subject have a clinical indication of ILD leading to VATS or open lung biopsy? ilddiag

   C. Does the subject have COPD leading to treatment with lung volume reduction surgery? 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? ipfcopd2

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

   F. Clinical indication for lung surgery is ILD: surgipf

3. Exclusion Criteria:

   A. Has the patient been diagnosed with an active primary infectious process (e.g. tuberculosis)? priminf
      Yes (1) No (2)

   B. Is there a primary diagnosis of cystic fibrosis or pulmonary hypertension listed as the reason for a transplant? excidia3
      Yes (1) No (2)
The patient is eligible for the main study 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.

A. Has consent been obtained for the genetics testing? (1) (2) genecons
B. Has consent been obtained for the LTRC protocol CT? (1) (2) ctcons

5. Is the patient eligible for the LTRC main study? (1) (2) eligible

*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 0 1 ___ compl_dt
   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)     gender
                   Female (2)

3. What is your ethnicity? Hispanic or Latino (1) ethnic
                           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) race_a
   B. Asian (1) race_b
   C. Black or African American (1) race_c
   D. Native Hawaiian or other Pacific Islander (1) race_d
   E. White (1) race_e
   F. Chooses Not to Disclose (1) race_f
II. ADMINISTRATIVE MATTERS

1. General comments:
   gen_cmnt
   __________________________________________________________
   __________________________________________________________

2. Research coordinator:
   A. Signature: ________________________________ cert_sig
   B. LTRC Staff No.: ___ ___ ___  ___ ___ ___ cert_no

3. Date Form Completed: ___ ___ ___ - ___ ___ - 2 0 1 ___ compl_dt
   Month  Day  Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CHANGE OF PROCEDURE/DEACTIVATION FORM

ID Number: 0 0 - 
Letter Code: 

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

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: vis_dt
   --- - 2 0 1
   Month   Day   Year

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) interval
   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)

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

   For transplant patients, skip Item 2I.

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

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.
Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

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: ___ ___ ___ - ___ ___ - 2013  
   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)   statedis
   B. Blood (1) (2) (3)   statbld
   C. CT Scan (1) (2) (3)   statct

III. ADMINISTRATIVE MATTERS

1. General Comments: ________________________________________________

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

3. Date form completed: ___ ___ ___ - ___ ___ - 2013  
   Month  Day  Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
VITAL STATUS FORM

ID Number: 0 0 - - - - - -
Letter Code: 
Visit Number: 0 2

1. Date of Report: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ vis_dt
   Month   Day                      Year

I. VITAL STATUS

1. Subject is (1) Living (2) Deceased (3) Unknown vital_st

If subject is “Living” go to Item 3. If “Unknown” go to Part II.

2. Date subject deceased: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ deceased
   Month           Day                Year

3. Method of Notification notify

Choose one of the following: National Death Index (1)
Hospital Record (2)
Family notified the clinic/hospital (3)
Other (4)

A. If Other, Specify__________________________________________ notifyot

II. ADMINISTRATIVE MATTERS

1. General comments:

_________________________________________________________ gen_cmnt

_________________________________________________________

2. Research Coordinator:

A. Signature: ____________________________________________ cert_sig

B. LTRC Staff No.: _____ _____ _____ _____ _____ _____ _____ cert_no

3. Date Form Completed: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ compl_dt
   Month   Day                     Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
MEDICAL HISTORY QUESTIONNAIRE

ID Number: 0 0 - Letter Code: 
Visit Number: 

1. Date of Interview: ___ ___ ___ - ___ ___ - 2011
   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:
R. Gastroesophageal Reflux Disease (GERD)  
S. Asthma  

↓  
↓  

If NO, or DON'T KNOW, go to T.

1. Was it confirmed by a doctor?  

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?  

bronchag Age in Years  

If NO or DON'T KNOW, go to Question 3

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.
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_lg
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?  
   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) a1adefc

3. Has a doctor told you that you have a fibrotic lung disease?  (1) (2) (3) fibridis
   If NO or DON’T KNOW, go to Part III.

4. Was the fibrotic lung disease documented by surgical biopsy?  (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:  ___ ___ ___ - ___ ___ - 2 0 1
g    Month    Day     Year

                      compl_dt
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
FAMILY HISTORY QUESTIONNAIRE

1. Date of Interview: ___ ___ ___ - ___ ___ - 2001

   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
   (1) (2) parents

   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?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Emphysema</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Asthma</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
</tbody>
</table>

Yes No Unknown
rel_copd rel_bron rel_emph

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

(1) (2) (3) rel_alad

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

(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?

(1) (2) (3) rel_biop

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Scleroderma</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Lupus</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Polymyositis</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Other collagen vascular disease</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>1) If YES to E, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other collagen vascular disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
</tbody>
</table>

Yes No Unknown
rel_arth rel_sclr rel_lups rel_pmyo rel_ovas rel_sp rel_phyp
II. ADMINISTRATIVE MATTERS

1. General Comments: ______________________________________________
   ______________________________________________
   ______________________________________________
   gen_cmnt

2. Research Coordinator:
   A. Signature: ______________________________________________
   cert_sig
   B. LTRC Staff No. ___ ___ ___   ___ ___ ___
   cert_no

3. Date Form Completed: ___ ___ ___ - ___ ___ - 2 0 1 ___
   Month  Day  Year
   compl_dt
LUNG TISSUE RESEARCH CONSORTIUM
SMOKING HISTORY FORM

ID Number: 0 0 -
Letter Code: 
Visit Number: 0 1

1. Date of Interview: ___ ___ ___ - ___ ___ - ___ ___
   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 No
      (1) (2) smokcig
      IF NO, GO TO 2A.
   B. Do you now smoke cigarettes?
      Yes No
      (1) (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.
cstopmon cstopyr
   E. When did you stop smoking cigarettes?
      ___ ___ - ___ ___ ___ ___
      Month    Year

2. CIGARS/CIGARILLOS/PIPES
   A. Have you ever smoked at least 100 cigars, cigarillos or pipes in your lifetime?
      Yes No
      (1) (2) smokoth
      IF NO, GO TO 3A.
ID Number: 0 0 - - - - -
Letter Code: 
Visit Number: 0 1

B. Do you now smoke cigars, cigarillos or pipes? (1) (2) smoknow2

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

- Less than one (1) smoknum
- 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? ___ ___ smokyrs

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

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

Month - Year

3. PASSIVE SMOKE EXPOSURE

A. Have you ever lived in a household in which people smoked? (1) (2) (3) smokhous

B. Have you ever worked in an environment with significant second-hand smoke exposure? (1) (2) (3) smokwork

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? ≤ 10 Yrs > 10 Yrs (1) (2) smoklen

D. Did your mother smoke while she was pregnant with you? (1) (2) (3) momsmok
II. ADMINISTRATIVE MATTERS

1. General Comments: ________________________________________________
   gen_cmnt
   ________________________________________________

2. Research Coordinator:

   A. Signature: _______________________________________________________
      cert_sig

   B. LTRC Staff Number: ___ ___ ___   ___ ___ ___   cert_no

3. Date Form Completed:       ___ ___ - ___ ___ - 2  0  1   compl_dt
      Month     Day     Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CONCOMITANT THERAPY FORM

ID Number: 0 0 -     -
Letter Code:  

Visit Number (Check only one):
Main study: 01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

1. Date of Interview: ___ ___ ___ - ___ ___ - 2 0 1 ___
   Month        Day           Year

I. SPECIFIC MEDICAL TREATMENT INFORMATION

1. Have you taken the following medications in the 30 days prior to today (main study enrollment visit 01) or since last visit (non-enrollment visit)?

   A. Systemic (Oral or IV) corticosteroids
      (e.g. prednisone, Medrol) (1) (2) ssteroid
   B. Interferon (gamma or beta) (1) (2) interfn
   C. Immune suppressive agents
      (such as cyclophosphamide, azathioprine, mycophenylate, TNF-alpha antagonists, methotrexate, or other immune suppressive agents or investigational drugs) (1) (2) immsupp
   D. Chemotherapy for cancer
      (such as Bleomycin, cyclophosphamide, ARA-C, Nitrosoureas, Gemcytibine, Imuran, Iressa) (1) (2) chemocan

2. Have you ever taken the following medications prior to enrollment (visit 01) or since last visit (non-enrollment visit)?
   If YES, please specify the duration (number of years) of use and how long ago (in years) you stopped.

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>Ever or since last visit</th>
<th>Duration Number of Years</th>
<th>How Long ago Stopped in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes          No</td>
<td>amio_dur     amio_stp</td>
<td>nitr_dur     nitr_stp</td>
</tr>
<tr>
<td></td>
<td></td>
<td>amio_ev</td>
<td>(1) (2)</td>
<td>_____ . .</td>
</tr>
<tr>
<td></td>
<td></td>
<td>nitr_ev</td>
<td>(1) (2)</td>
<td>_____ . .</td>
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<tr>
<td></td>
<td></td>
<td>chem_ev</td>
<td>(1) (2)</td>
<td>_____ . .</td>
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<td>(1) (2)</td>
<td>_____ . .</td>
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<td>trad_dur</td>
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<tr>
<td></td>
<td></td>
<td>trad_stp</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
II. OTHER MEDICATION INFORMATION

1. Have you taken any inhaled steroids (e.g. Flovent, Pulmicort, Aerobid, Advair) in the last 30 days (main study enrollment visit 01) or since last visit (non-enrollment visit)?
   [ ] Yes  [ ] No

2. Have you taken any of the following types of bronchodilator medication in the last 30 days (main study enrollment visit 01) or since last visit (non-enrollment visit)?
   A. Inhaled beta-agonists such as Serevent, salmeterol, Ventolin, Proventil, Albuterol, Foradil
      [ ] Yes  [ ] No

   B. Anticholinergics such as Atrovent, Combivent, Spiriva
      [ ] Yes  [ ] No

   C. Oral beta-agonists, such as Brethaire, Ventolin, Proventil.
      [ ] Yes  [ ] No

   D. Theophylline
      [ ] Yes  [ ] No

   E. Other
      [ ] Yes  [ ] No
      1) If YES to E, specify: _______________________

3. Have you taken any of the following types of medications within the last 30 days (main study enrollment visit 01) or since last visit (non-enrollment visit)? If YES, please specify the duration of use. If 3.B is Yes, please select 1 type of statins from the following:
   A. Ace Inhibitor
      [ ] Yes  [ ] No
      ___ ___ . ___
   B. Statins
      [ ] Yes  [ ] No
      ___ ___ . ___

   1) Simvastatin (Zocor®, Vytorin®, Simlip®, Simcor®, Simcard®, Lipex®, Inegy®)
   2) Lovastatin (Advicor®, Altocor®, Altoprev®, Mevacor®)
   3) Atorvastatin (Atorlip®, Lipitor®, Caduet®, Lipvas®, Sortis®, Torvacard®, Torvast ®, Totalip®, Tulip®) stat_typ
   4) Rosuvastatin (Crestor®)
   5) Pravastatin (Selektine®, Pravachol®, Lipostat®)
   6) Fluvastatin (Canef®, Lescol®)
   7) Pitavastatin (Pitava®, Livalo®)
   8) Other
      i) If Other, specify: _______________________

   C. Macrolides
      [ ] Yes  [ ] No
      ___ ___ . ___
   D. Cox-2 Inhibitors
      [ ] Yes  [ ] No
      ___ ___ . ___

   E. Ketaconazole
      [ ] Yes  [ ] No
      ___ ___ . ___
Visit Number (Check only one):
Main study: 01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

III. ADMINISTRATIVE MATTERS

1. General Comments: _____________________________________________

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

3. Date form completed: _______ - ______ - 2011
   Month       Day     Year
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
SYMPTOM QUESTIONNAIRE

ID Number: 0 _ _ _ Letter Code: _ _ _ _ _ 
Visit Number: 0 _ _ _ _ _ 

1. Date of Interview: ___ ___ - ___ - ___ 2001
   Month Day Year
   vis_dt

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) cough
   (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 at all on getting up, or first thing in the morning? (1) (2) cougham

4. Do you usually cough at all during the rest of the day or night? (1) (2) coughpm
   If YES to any of questions 1-4, go to Question 5. If NO to all questions, go to Part II.

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? (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? (1) (2) epiwks
   
   If NO, go to Part IV.

2. For how long have you had at least one such episode per year? __ __ Years
   
   Don't Know (1)
IV. WHEEZING

1. Does your chest ever sound wheezy or whistling?
   A. When you have a cold? (1) (2) cold
   B. Occasionally, apart from colds? (1) (2) nocold
   C. Most days or nights? (1) (2) wheeze

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

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

3. Have you ever had an attack of wheezing that has made you feel short of breath? (1) (2) shrtbr

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

5. Have you had two or more such episodes? (1) (2) shrtbr2

6. Have you ever required medicine or treatment for the(se) attack(s)? (1) (2) shrtbrrx

7. Have you had an attack of wheezing that has made you feel short of breath in the past year? (1) (2) shrtbryr

   If NO, go to Part V.

8. Have you had two or more such episodes in the past year? (1) (2) shrbryr2

9. Have you required medicine or a treatment for the(se) attack(s) in the past year? (1) (2) shrbrrx2

V. BREATHLESSNESS

1. Are you disabled from walking by any condition OTHER than heart or lung disease? (1) (2) cantwalk
   If YES, please describe the nature of the condition(s):
   A. ___________________________________________________________
      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? (1) (2) shrbrh1

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? (1) (2) walkslow

C. Do you ever have to stop for breath when walking at your own pace on the level? (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? (1) (2) walkdist

E. Are you too breathless to leave the house or breathless on dressing or undressing? (1) (2) cantleav

VI. CHEST COLDS AND CHEST ILLNESSES

1. How often do you get colds?

   Less often than once a year (1) oftcold
   Once a year (2)
   2-4 times per year (3)
   5 or more times per year (4)

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

2. Do your colds usually go to your chest? (1) (2) chstcold
   (“Usually” means more than half the time).

3. How often did you get colds in the past 12 months?

   Not at all (1) oftcold2
   Once (2)
   2-4 times (3)
   5 or more times (4)

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   No
   (1)   (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   No
   (1)   (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
   chstnbr

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

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

VII. ADMINISTRATIVE MATTERS

1. General Comments: __________________________________________
    gen_cmnt

2. Research Coordinator:
   __________________________
   cert_sig
   B. LTRC Staff Number: ___ ___ ___ ___ ___ ___
    cert_no

3. Date Form Completed:    ___  ___  -  ___  ___  -  2  0  1
   Month  Day  Year
    compl_dt
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
SF-12 HEALTH SURVEY

ID Number: 0 0 - 
Letter Code: 
Visit Number: 0 1

1. Date of Interview: _____ - _____ - 2 0 1 
   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: 
   Excellent Very Good Good Fair Poor
   ▼ ▼ ▼ ▼ ▼
   (1 ) (2 ) (3 ) (4 ) (5 )

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 )
      phyftn1

   B. Climbing several flights of stairs
      (1 ) (2 ) (3 )
      phyftn2

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

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
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?  
B. Did you have a lot of energy?  
C. Have you felt downhearted and depressed?

<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>

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 0 1 ___
   Month     Day   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: wheez4wk
   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)

5. During the last 4 weeks, how many severe or very unpleasant episodes of lung/respiratory problems have you had: resp4wk
   More than three episodes (1)
   Three episodes (2)
   Two episodes (3)
   One episode (4)
   No episodes (5)

6. How long did the worst episode of lung/respiratory problem last: resplen
   A week or more (1)
   Three or more days (2)
   One or two days (3)
   Less than a day (4)

7. Over the last 4 weeks, in an average week, how many good days (with few lung/respiratory problems) have you had: gddy4wk
   None (1)
   One or two (2)
   Three or four (3)
   Nearly every day (4)
   Every day (5)

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

9. How would you describe your lung/respiratory condition (check one only):   respdesc

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:                               respjob

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:       (1 ) ( 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) cghtire

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: (1) (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: (1) (2) respact1
37. I cannot take a bath or shower, or I take a long time: (1) (2) respact2
38. I walk slower than other people my age, or I stop to rest: (1) (2) respact3
39. Jobs such as household chores take a long time, or I have to stop to rest: (1) (2) respact4
40. If I walk up one flight of stairs, I have to go slowly or stop: (1) (2) respact5
41. If I hurry or walk fast, I have to stop or slow down: (1) (2) respact6
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 horseshoes: (1) (2) respact7
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) respact8
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) respact9
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. ____________________________________________________________ INTACT1
b. ____________________________________________________________ INTACT2

c. ____________________________________________________________ INTACT3

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: ____________________________________________
   gen_cmnt
   ________________________________________________________________

2. Research Coordinator:
   
   A. Signature: ____________________________________________
      cert_sig

   B. LTGC Staff No. ___ ___ ___ ___ ___ ___ ___
      cert_no

3. Date Form Completed: ___ ___ - ___ - 2001 compl_dt
   Month Day Year
**LUNG TISSUE RESEARCH CONSORTIUM (LTRC)**
**ENVIRONMENTAL QUESTIONNAIRE**

**ID Number:** 0 0

**Letter Code:**

**Visit Number:** 0 1

1. **Date of Interview:** ___ ___ ___ - ___ ___ - 2 0 1 ___
   
   **Month**  **Day**  **Year**

   **vis_dt**

**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>Yes</th>
<th>No</th>
<th>Don't Know</th>
<th>Number of Years</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heat1</td>
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<td>2</td>
<td>3</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
<th>Number of Years</th>
<th>Don't Know</th>
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<tr>
<td>A. humidifier/Cool Mist Vaporizer</td>
<td>dev1</td>
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<td>2</td>
<td>3</td>
<td>dev1yr</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>B. Sauna/Hot tub</td>
<td>dev2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>dev2yr</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</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)?
III. ADMINISTRATIVE MATTERS

1. General Comments: ____________________________________________
   __________________________________________________________________

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

3. Date Form Completed:  ____ ____ - ____ ____ - 2 0 1 ___
   Month   Day   Year

ID Number: 0 0 - ________ - ________
Letter Code: ______________________
Visit Number: ________ 0 1
I. OCCUPATIONAL AND ENVIRONMENTAL QUESTIONNAIRE

LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
OCCUPATIONAL AND ENVIRONMENTAL QUESTIONNAIRE

| ID Number: | 0 0 - | |
| Letter Code: | |
| Visit Number: | 0 1 |

1. Date of Interview: _______ - _______ - 2 0 1 vis_dt
   Month       Day       Year

1. 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>Job Category</th>
<th>Yes Job Code</th>
<th>No Job Code</th>
<th>Years</th>
<th>Don't Know Job Code</th>
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<tbody>
<tr>
<td>Aircraft/aerospace manufacturing</td>
<td>jobacm</td>
<td>jobacmyr</td>
<td></td>
<td>jobacmdk</td>
</tr>
<tr>
<td>Animal laboratory worker</td>
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<td>jobalwdk</td>
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<tr>
<td>Auto or truck repair</td>
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<td></td>
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<td>Raising birds</td>
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<td></td>
<td>jobcwwdk</td>
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<tr>
<td>Construction</td>
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<td>jobconyr</td>
<td></td>
<td>jobcondk</td>
</tr>
<tr>
<td>Demolition of buildings</td>
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<td>jobdobyr</td>
<td></td>
<td>jobdobdk</td>
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<td></td>
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<td>jobfrlyr</td>
<td></td>
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<tr>
<td>Fire fighter</td>
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<td>In a sawmill</td>
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</tr>
<tr>
<td>In a pulpmill</td>
<td>jobpm</td>
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<tr>
<td>Hairdressing or cosmetology</td>
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<td></td>
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<tr>
<td>Meat wrapping</td>
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<td>Any type of mining</td>
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</tbody>
</table>
ID Number: 0 0 -  
Letter Code:  
Visit Number: 0 1

A  
Employment  Number  Don’t  
Yes  No  of Years  Know  

21. Pottery making or ceramics (1) jobpmc (2) jobpmcyr ___ ___ (1) jobpmcdk  
22. Working in a quarry (1) jobqua (2) jobquayr ___ ___ (1) jobquadk  
23. Sandblasting (1) jobsb (2) jobsbyr ___ ___ (1) jobsbdk  
24. Smelting in a foundry (1) jobsf (2) jobsfyr ___ ___ (1) jobsfdk  
25. Stone cutting or polishing (1) jobscp (2) jobscpyr ___ ___ (1) jobscpdk  
26. Tunnel construction (1) jobtc (2) jobtcyr ___ ___ (1) jobtcdk  
27. Veterinarian/veterinary work (1) jobvet (2) jobvetyr ___ ___ (1) jobvetdk  
28. Welding (1) jobwld (2) jobwldyr ___ ___ (1) jobwlddk  
29. Rubber factory worker (1) jobrfw (2) jobrfwyr ___ ___ (1) jobrfwdk  
30. In a pet store (1) jobps (2) jobpsyr ___ ___ (1) jobspdk  
31. In an occupation with radiation exposure (1) jobrde (2) jobrdeyr ___ ___ (1) jobrdedk  

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.  

Exposure  Number  Don’t  
(A)  (B)  of Years  Know  
wrkenv  wrkenvyr  wrkenvdk  

Yes  No  ___ ___  (1)  
(1)  (2)  

II. ADMINISTRATIVE MATTERS  

1. General Comments: ______________________________________________________ gen_cmnt  

2. Research Coordinator:  

   A. Signature: ___________________________________________________________ cert_sig  
   B. LTRC Staff Number: ___ ___ ___ ___ ___ ___ ___ cert_no  

3. Date Form Completed:  
   Month - Day - Year  
   ___ ___ - ___ ___ - 2 0 1  
   compl_dt
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
SIX MINUTE WALK TEST

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

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

I. SIX MINUTE WALK TEST

1. Is the test performed as:
   LTRC Protocol       (1) smw_why
   Clinical Care       (2)
   Yes     No

2. Is resting O₂ saturation at least 88% after appropriate O₂ titration?  
   (1)    (2) reso2sat
   If NO, and test performed as LTRC Protocol, go to Part II.

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

4. Borg scale rating for perceived breathlessness at rest:       ____ ____ . ___    (1) rborgnd

5. Borg scale rating for leg fatigue at rest:                          ___ ___ . ___      (1) rlgorgnd

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

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

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
    tmrborg 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.

   A. Test lasted six minutes
      (1) term6min
   B. Chest pain:                     (1) termcp
   C. Near syncope:                   (1) termsyn
   D. Ataxic gait:                    (1) termatax
   E. Lower extremity claudication:   (1) termclau
F. Mental confusion: 

| ID Number: | 0  | 0 | - | | | | | |
| Letter Code: | | | | | |

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

G. Patient refused to continue: (1) termref
H. Leg Fatigue (1) termleg
I. Staff request: (1) termstaf
J. Other (1) termoth
   1) Specify ___________________________________________ term_sp

II. ADMINISTRATIVE MATTERS

1. General Comments: ___________________________________________ gen_cmnt

2. Six Minute Walk Tester:
   A. Signature: ______________________________________________ test_sig
   B. LTRC Staff No. ___ ___ ___ ___ ___ ___ test-no

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

4. Date Form Completed: ___ ___ - ___ ___ - 2 0 1 ___ compl_dt
   Month Day Year
**LUNG TISSUE RESEARCH CONSORTIUM (LTRC)**

**CARDIOPULMONARY EXERCISE TESTING FORM**

| ID Number: | 0 0 -   | Letter Code: |   |
| Form Type: | C E 0 1 |

1. Date of Examination: ________ - ________ - 2000 vis_dt
   Month    Day    Year

I. PRELIMINARY TEST INFORMATION

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

2. Best FEV$_1$: ___. ___ _ L bestfev1

   \[ \text{FEV}_1 \times 40 = \text{MVV (L/min)} \]
   - If MVV \( \leq 40 \text{ L/min} \), then use ramp rate of 5 watts/min
   - If MVV \( > 40 \text{ L/min} \) but \( < 80 \text{ L/min} \), then use ramp rate of 10 watts/min
   - If MVV \( \geq 80 \text{ L/min} \), then use ramp rate of 15 watts/min

3. Ramp Rate for exercise test:
   - 5 watts/min (1)
   - 10 watts/min (2)
   - 15 watts/min (3)
## II. CARDIOPULMONARY EXERCISE TEST

<table>
<thead>
<tr>
<th>Quantity</th>
<th>A 5 Minute Rest</th>
<th>B 3 Minute Unloaded</th>
<th>C Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was test completed?</td>
<td>Yes (1) No (2)</td>
<td>Yes (1) No (2)</td>
<td>Yes (1) No (2)</td>
</tr>
<tr>
<td>Complete for LEVEL I and II Testing</td>
<td>cmp5mrst cmp3munl cmpmax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Exercise F:\O2</td>
<td>exerfio2</td>
<td>Room Air (0.21) (1) 30% Oxygen (0.30) (2)</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Barometric Pressure (mmHg):</td>
<td>XXX</td>
<td>barpresa</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Equipment Deadspace (cc):</td>
<td>XXX</td>
<td>eged espa</td>
<td>N/A</td>
</tr>
<tr>
<td>5. SpO(2) (%):</td>
<td>XXX</td>
<td>spo2a spo2b spo2c</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Ve (BTPS; L/min)</td>
<td>XXX.X</td>
<td>vebtpsa vebtpsb vebtpsc</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Vt (BTPS; L)</td>
<td>X.XX</td>
<td>vtbtpsa vtbtpsb vtbtpsc</td>
<td>N/A</td>
</tr>
<tr>
<td>8. VO(2) (STPD; L/min)</td>
<td>X.XXX</td>
<td>vo2stpda vo2stpdb vo2stpdsc</td>
<td>N/A</td>
</tr>
<tr>
<td>9. VCO(2) (STPD; L/min)</td>
<td>X.XXX</td>
<td>vco2a vco2b vco2c</td>
<td>N/A</td>
</tr>
<tr>
<td>10. Heart Rate (beats/minute)</td>
<td>XXX</td>
<td>hrtratea hrtrateb hrtratec</td>
<td></td>
</tr>
<tr>
<td>11. Respiratory Rate (breaths/minute)</td>
<td>XX</td>
<td>respa respb respc</td>
<td></td>
</tr>
<tr>
<td>12. Systolic blood pressure (mmHg)</td>
<td>XXX</td>
<td>sbpa sbpb sbpc</td>
<td></td>
</tr>
<tr>
<td>13. Diastolic blood pressure (mmHg)</td>
<td>XXX</td>
<td>dbpa dbpb dbpc</td>
<td></td>
</tr>
<tr>
<td>14. Borg (breathlessness)</td>
<td>XX.X</td>
<td>borgbta borgbtb borgbtc</td>
<td></td>
</tr>
<tr>
<td>15. Borg (leg muscle fatigue)</td>
<td>XX.X</td>
<td>borglga borglgb borglgc</td>
<td></td>
</tr>
<tr>
<td>16. Load (watts)</td>
<td>XXX</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Complete for LEVEL II Testing Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. P(a)O(2) (mmHg)</td>
<td>XXX</td>
<td>pao2a pac2b pao2c</td>
<td></td>
</tr>
<tr>
<td>18. P(a)CO(2) (mmHg)</td>
<td>XXX</td>
<td>paco2a paco2b paco2c</td>
<td></td>
</tr>
<tr>
<td>19. pH</td>
<td>X.XX</td>
<td>pha phb phc</td>
<td></td>
</tr>
<tr>
<td>20. Base Excess</td>
<td>XX.XX</td>
<td>basexa basexb basexc</td>
<td></td>
</tr>
<tr>
<td>21. FE(CO(2)</td>
<td>X.XXXX</td>
<td>feco2a feco2b feco2c</td>
<td></td>
</tr>
</tbody>
</table>

22. Did the staff member terminate the test?  Yes (1) No (2) stterm

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 (1) stcad
B. Mental confusion (1) stment
C. EKG arrhythmia (1) starrhy
D. EKG ischemia (1) stisch
E. Elevated blood pressure (1) stelevbp
F. Low blood pressure (1) stlownp
G. Other (1) stoth
1) Specify ________________________________
23. Did the patient terminate the test?

Yes (1) No (2) ptterm

If NO, go to Part III.

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

A. Dyspnea or shortness of breath (ptdysp
B. Dizziness or lightheadedness (ptdizz
C. Chest pain (ptcthp
D. Leg fatigue (ptleg
E. Other (ptoth
1) Specify __________________________________________

III. ADMINISTRATIVE MATTERS

1. General Comments: __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

2. Cardiopulmonary Exercise Tester:
   A. Signature: __________________________________________

3. Research Coordinator:
   A. Signature: __________________________________________

4. Date Form Completed: _____ _____ - _____ _____ - 2 0 0 __
   Month Day Year

   gen_cmnt
   cpex_sig
   cpex_no
   cert_sig
   cert_no
   compl_dt
LUNG TISSUE RESEARCH CONSORTIUM
PULMONARY FUNCTION TESTING

ID Number: 00 - -
Letter Code: -

Visit Number (Check only one):
01 ☐, 02 ☐, 03 ☐, 04 ☐, 05 ☐, 06 ☐, 07 ☐, 08 ☐, 09 ☐, 10 ☐, 11 ☐

1. Date of Study Visit: _____ _____ - _____ - 2 0 1
   Month   Day   Year

I. DEMOGRAPHIC INFORMATION

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

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)

   If Spirometry not done, go to Part III.

   A. Date of Spirometry: _____ _____ - _____ - 2 0 1
      Month   Day   Year

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 pre_fev1 Not Done (1)
   B. FVC: ____ . _____ L pre_fvc Not Done (1)
   C. FEV₆: ____ . _____ L prfev6 Not Done (1)
   D. PEFR: _____ . _____ L/Second prpefr Not Done (1)
Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

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) pobs_nd

**IF POST-BRONCHODILATOR SPIROMETRY NOT DONE, GO TO PART III.**

B. FEV₁: ___ . ___ ___ L pos_fev1 Not Done (1) pofev_nd
C. FVC: ___ . ___ ___ L pos_fvc Not Done (1) pofvc_nd
D. FEV₆: ___ . ___ ___ L pofev6 Not Done (1) pofev6nd
E. PEFR: _____ . ____ L/Second popefr Not Done (1) popefrnd
F.* Vext: ___ . ___ ___ ___ L vext Not Done (1) vext_nd
G.* FET₁₀₀%: _____ . ___ Second fet100 Not Done (1) fet100nd

*QC Items

III. LUNG VOLUME

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

   **IF LUNG VOLUME NOT DONE, GO TO PART IV**

A. Date lung volume performed: ___ ___ - ___ - ___ 0 1 ___ lungv_dt
   Month Day Year

2. Technique Plethysmography Helium Dilution Nitrogen Washout lvtechnq
   (1) (2) (3)

3. TLC: ____ . ____ ___ L mntlc Not Done (1) mntlc_nd
4. Maximum SVC: ___ . ____ ___ L maxsvc Not Done (1) mxsvc_nd
5. RV: ____ . ____ ___ L rv Not Done (1) rv_nd
6. Mean FRC: ____ . ____ ___ L mnfrc Not Done (1) mnfrc_nd
7. Raw-insp ___ ___ . ____ ___ cm H₂O/Liters/Sec airwy Not Done (1) airwy_nd
8. sGaw-insp ___ . ____ ___ ___ L/cm H₂O/Sec/Liter sgaw Not Done (1) sgaw_nd
Visit Number (Check only one):
01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11

IV. DIFFUSING CAPACITY (D\textsubscript{L}CO)

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

   **IF D\textsubscript{L}CO NOT DONE, GO TO PART V.**

   A. Date D\textsubscript{L}CO performed: ___ ___ - ___ ___ - 2 0 1 dlco\_dt
      Month Day Year

2. Mean D\textsubscript{L}CO: ___ ___ . ___ ml/min/mmHg mdlc\_co
   (uncorrected for hemoglobin)

3. V\textsubscript{I}: ___ . ___ ___ L vi

4. V\textsubscript{ALV} ___ ___ . ___ ___ L valv

V. ROOM AIR ARTERIAL BLOOD GAS ANALYSIS (ABG)

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

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

   A. Date of arterial blood draw: ___ ___ - ___ ___ - 2 0 1 artbl\_dt
      Month Day Year

2. PaO\textsubscript{2} ___ ___ ___ mmHg pao2

3. PaCO\textsubscript{2} ___ ___ ___ mmHg paco2

4. pH: ___ . ___ ___ ph

5. O\textsubscript{2} Sat: ___ ___ ___ . ___ % o2sat

6. COHb: ___ ___ . ___ gm % cohb
VI. ADMINISTRATIVE MATTERS

1. General Comments: ___________________________________________ gen_cmnt
   __________________________________________

2. PFT Tester:
   A. Signature: ___________________________________________ pft_sig
   B. LTRC Staff No. ___ ___ ___   ___ ___ ___ pft_no

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

4. Date form completed:  ____  ____  -   _______  -  ____  ____  ____  ____ compl_dt
   Month      Day     Year
**LUNG TISSUE RESEARCH CONSORTIUM**

**LABORATORY DATA FORM**

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

Visit Number (Check only one):

01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

1. Date of Examination:      _2_ _0__ _1_  
   Month   Day   Year  

**I. BLOOD TESTS**

**Complete Question 1 for all patients.**

1. CBC
   A. Date of CBC:      _2_ _0__ _1_  
                         Month   Day   Year  
   Not Done (1)  cbc_nd
   B. WBC:     ___ ___ . ___ X 10^9/L  wbc Not Done (1)  wbc_nd
   C. WBC Differential:
      1. neutrophilic ___ ___ . ___ ___ %  wbcdiff1
      2. lymphocytes ___ ___ . ___ ___ %  wbcdiff2
      3. monocytes ___ ___ . ___ ___ %  wbcdiff3
      4. eosinophils ___ ___ . ___ ___ %  wbcdiff4
      5. basophils ___ ___ . ___ ___ %  wbcdiff5
   D. Hgb:     ___ ___ . ___ g/dL  hgb Not Done (1)  hgb_nd
   E. Hematocrit:     ___ ___ . ___ %  hemcrt Not Done (1)  hemcr_nd
   F. Platelets:     ___ ___ ___ . ___ X 10^9/L  platlet Not Done (1)  plat_nd

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_ _0__ _1_  
                                Month   Day   Year  
   Not Done (1)  labch_nd
B. Rheumatoid Factor (RF):  rfcode (1) (2)  Present Absent  Not Done (3)  rf_nd
C. Creatine Kinase (CK):  ck ___ ___ ___ ___ U/L  Not Done (1)  ck_nd
D. Erythrocyte Sedimentation Rate (ESR):  esr ___ ___ ___ mm/hr  Not Done (1)  esr_nd
ID Number: 0 0 -
Letter Code: 

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

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) □

3. OTHER CHEMISTRIES

Required for non-ILD patient. Abstract for ILD patient if available.

A. Alpha-1 Antitrypsin Level ___ ___ ___ mg/dL alalevel Not Done (1) alalv_nd

II. ADMINISTRATIVE MATTERS

1. General Comments: ____________________________________________
   gen_cmnt
   ______________

2. Research Coordinator:

A. Signature: ______________________________________________
   cert_sig

B. LTRC Staff No. ___ ___ ___ ___ ___ ___
   cert_no

3. Date Form Completed: ___ ___ ___ - ___ ___ - 2001
   Month Day Year compl_dt
The Collection Time is the time when the tissue is first excised from the lung.

1. A. Collection Date of tissue specimens: _______ - ______ - 2011 vis_dt
   Month coltm_hr Day coltm_mn Year

   B. Collection Time of tissue specimens: ____ ____ : ____ ____
      H r Min

I. SHIPPING INFORMATION

   This mailing form must be completed for each tissue specimen that is collected to be shipped to LTRC at National Jewish Health. 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 label here): ___________________________ tissnum

2. Type of tissue submitted for this case: (check one) tisstyp
   Lung explant, single (1)
   Lung explant, bilateral (2)
   Lung lobectomy (3)
   Lung biopsy/wedge resection (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 0 1
   fix Dt
   Month Day Year
   fixtm_hr fixtm-mn

   B. Fixative Completion Time: ____ : ____
   Hr Min

5. Specimens submitted:

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th># of Containers with Tissue Shipped to TCL*</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Formalin-fixed, strips</td>
<td>tspec_b</td>
</tr>
<tr>
<td>D. RNAlater</td>
<td>tspec_d</td>
</tr>
<tr>
<td>E. Flash frozen</td>
<td>tspec_e</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 0 1
   Month Day Year
   ship_dt

II. Administrative Matters

1. General Comments: __________________________________________
   gen_cmnt
   __________________________________

2. Shipped by:

   A. Signature: __________________________________________
      cert_sig

   B. Telephone Number: (___ ___ ___) ___ ___ ___ ___ ___ ___ ___
      shiptel

   C. LTRC Staff No. ___ ___ ___ ___ ___ ___ ___ ___
      cert_no

3. Date Form Completed: ____ ___ ___ - ___ ___ - 2 0 1
   Month Day Year
   compl_dt

CALL TCL AT (303) 398-1449 TO NOTIFY THEM THAT A SHIPMENT WILL BE SENT VIA FEDEX OR UPS AND PROVIDE THEM WITH THE TRACKING NUMBER(S). FOLLOW BATCH SHIPPING SCHEDULE. DO NOT SEND THIS FORM TO THE TCL.
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
BLOOD COLLECTION MAILING FORM

ID Number: 0 0 - - -  -
Letter Code: -

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

1. Collection Date of Blood Specimen: _____ _____ - _____ - 2 0 1 1  vis_dt
         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 NATIONAL JEWISH HEALTH. A SHIPPING LIST TO BE SENT WITH THE BLOOD
WILL BE GENERATED WHEN DATA ENTRY OF THIS FORM IS COMPLETE.

1. Blood ID Number ____________________________ bldnum
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 0 1 1  blshp_dt
       Month   Day     Year

II. ADMINISTRATIVE MATTERS

1. General Comments: ____________________________________________ gen_cmnt

__________________________________________________________

2. Shipped by:
   A. Signature: ______________________________________________ cert_sig
   B. Telephone Number: (__ __ __) __ __ __ __ __ __ __ __ __ __ bshptel
   C. LTRC Staff Number: __ __ __ __ __ __ __ __ __ __ cert_no

3. Date form completed: _____ _____ - _____ - 2 0 1 1  compl_dt
       Month   Day     Year

CALL TCL AT (303) 398-1449 TO NOTIFY THEM THAT A SHIPMENT WILL BE SENT VIA FEDEX OR
UPS AND PROVIDE THEM WITH THE TRACKING NUMBER(S). FOLLOW BATCH SHIPPING
SCHEDULE. DO NOT SEND THIS FORM TO THE TCL.
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CT SHIPPING RECORD

| ID Number: | 0 0 | - | - |
| Letter Code: | | | |

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

1. Date of CT Scan Acquisition: __ __ __ - __ __ - 2 0 1 __ 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: scanprot
      Retrospective CT obtained at Clinical Center (3)
      Retrospective CT from Outside Media (CD etc.) (4)
      LTRC Protocol CT (5)

   B. Series Number
   C. Number of Images

<table>
<thead>
<tr>
<th>Sequence</th>
<th>B. Series Number</th>
<th>C. Number of Images</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

2. Radiologist Input: scan_dt
   A. Date of CT Scan Interpretation: __ __ __ - __ __ - 2 0 1 __
      Month Day Year

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

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

   C. Date of CT Transfer: __ __ __ - __ __ - 2 0 1 __
      Month Day Year cttrn_dt

   D. Shipped by: ____________________________
      ctshpnam

   E. Date of shipment: __ __ __ - __ __ - 2 0 1 __
      Month Day Year ctshp_dt
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
CT SHIPPING RECORD

ID Number: 0 0 -
Letter Code: 

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

II. ADMINISTRATIVE MATTERS

1. General Comments: _____________________________________________________________
   2. CT Technologist:
      A. Name: __________________________________________                     ct_nam
      B. LTRC Staff Number: ___ ___ ___ ___ ___ ___ ___                     ct_no

3. Study Coordinator:
   A. Signature: ____________________________________________________________
      B. LTRC Staff Number: ___ ___ ___ ___ ___ ___ ___                     cert_no

4. Date form completed: ___ ___ ___ - ___ ___ - 2 0 1                     compl_dt

   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:

   Kathleen Mieras         AIPL 3D Lab
   Phone: (507) 284-9187    Phone: (507) 284-1424
   Fax: (507) 538-0593      Fax: (507) 538-7076

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

CT Number: [ ] [ ] [ ] [ ]
Visit Number: 0 1

1. Date of Report: ___ ___ ___ - ___ ___ - 2 0 1 ___ vis_dt
   Month Day Year

I. QUANTITATIVE IMAGE ANALYSIS RESULTS

1. CT Acceptable for Quantitative Analysis (1) (2) ctabcept
   A. If NO, then specify reason:
      (1) Not LTRC or other volumetric HRCT ctabc_rs
      (2) Other (Specify): __________________________ ctabc_sp

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

2. 3D Image analysis results Not Done (1) imag3dnd
   A. Histogram analysis (1) (2) histanl
   B. Texture analysis (1) (2) textanl
   C. Bronchial branching analysis (1) (2) bronanl

3. Date of Analysis: ___ ___ ___ - ___ ___ - 2 0 1 ___ anl_dt
   Month Day Year

4. CT Analyst Name: ______________________________________ anl_nam

5. LTRC Staff No.: ____________________________ anl_no

II. QUALITATIVE IMAGE ASSESSMENT AND DESCRIPTION

1. CT Study Verification and Image Quality
### CT Scan Report

<table>
<thead>
<tr>
<th>A. Series Number</th>
<th>B. Description*</th>
<th>C. Image Count</th>
<th>D. Image Quality Assessment**</th>
<th>E. QA Problem Type***</th>
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<td>imcnt</td>
<td>imqual</td>
<td>imqprb</td>
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<td>30</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
## 2. Specific Regional Findings

<table>
<thead>
<tr>
<th>LUNG</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regional Distribution</strong></td>
<td><strong>(1) RIGHT</strong></td>
<td><strong>(2) LEFT</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Upper a</strong></td>
<td><strong>Middle b</strong></td>
</tr>
<tr>
<td></td>
<td><strong>(1) Central</strong></td>
<td><strong>(2) Peripheral</strong></td>
</tr>
<tr>
<td>A. Air Trapping</td>
<td>findaruc</td>
<td>findarup</td>
</tr>
<tr>
<td>B. Bronchial Thickening</td>
<td>findbruc</td>
<td>findbrup</td>
</tr>
<tr>
<td>C. Bronchiectasis</td>
<td>findcruc</td>
<td>findcrup</td>
</tr>
<tr>
<td>D. Bullae</td>
<td>finddrc</td>
<td>finddrrup</td>
</tr>
<tr>
<td>E. Consolidation</td>
<td>findercuc</td>
<td>findercrup</td>
</tr>
<tr>
<td>F. Crazy Paving Pattern</td>
<td>findfruc</td>
<td>findfrup</td>
</tr>
<tr>
<td>G. Emphysema</td>
<td>findgruc</td>
<td>findgrup</td>
</tr>
<tr>
<td>H. Ground Glass Infiltrates</td>
<td>findhucc</td>
<td>findhurup</td>
</tr>
<tr>
<td>I. Honeycombing</td>
<td>findirc</td>
<td>findirup</td>
</tr>
<tr>
<td>J. Micronodules (&lt;5 mm)</td>
<td>findjrc</td>
<td>findjrup</td>
</tr>
<tr>
<td>K. Mosaic Attenuation</td>
<td>findkrc</td>
<td>findkrlc</td>
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<tr>
<td>L. Pulmonary Cysts</td>
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<td>findlup</td>
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<td>M. Reticular Infiltrates</td>
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<tr>
<td>N. Septal Thickening</td>
<td>findnrc</td>
<td>findnrup</td>
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<tr>
<td>O. Tree in Bud Pattern</td>
<td>findoruc</td>
<td>findorup</td>
</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
### Ancillary Findings (Check if present)

<table>
<thead>
<tr>
<th></th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Evidence for prior Thoracic Surgery (Not CABG)</td>
<td>prsurgr</td>
<td>prsurgl</td>
</tr>
<tr>
<td>B. Pulmonary Nodules or Masses (&gt;10mm)</td>
<td>pnodr</td>
<td>pnodl</td>
</tr>
<tr>
<td>C. Parenchymal Bands</td>
<td>parbndr</td>
<td>parbndl</td>
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<tr>
<td>D. Giant Bulla (at least 1/3 volume of the lungs)</td>
<td>gbullar</td>
<td>gbullal</td>
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<tr>
<td>E. Pulmonary Cavities (thick walled)</td>
<td>pulcavr</td>
<td>pulcavi</td>
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<tr>
<td>F. Lobar or segmental collapse</td>
<td>lobcolr</td>
<td>lobcoll</td>
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<tr>
<td>G1. Hilar Mass/Adenopathy</td>
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<td>hmal</td>
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<td>G2. Mediastinal Mass</td>
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<td>H. Enlarged Pulmonary Arteries</td>
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<td>pulartl</td>
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<td>I. Pleural Thickening</td>
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<td>pleuthl</td>
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<tr>
<td>J. Pleural Effusion</td>
<td>pleuefr</td>
<td>pleuefl</td>
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<tr>
<td>K. Pleural Calcifications</td>
<td>pleucar</td>
<td>pleucal</td>
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<tr>
<td>L. Skeletal Deformity (scoliosis, kyphosis, compression fractures)</td>
<td>skdefr</td>
<td>skdefl</td>
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<tr>
<td>M. Other/Comments (e.g. esophageal dilatation, microlithiasis, etc. …specify)</td>
<td>Specify: __________________________</td>
<td>ctoth_sp</td>
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### Radiologist Summary Descriptions:

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<tr>
<th></th>
<th>ademphys</th>
<th>adintprc</th>
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<tbody>
<tr>
<td>A. Best Description of axial distribution of emphysema</td>
<td>C. Best description of axial distribution of interstitial process</td>
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<tr>
<td>(1) None</td>
<td>(1) None</td>
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<tr>
<td>(2) Peripheral/Subpleural</td>
<td>(2) Peripheral/Subpleural</td>
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<tr>
<td>(3) Central/Axial</td>
<td>(3) Central/Axial</td>
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<td>(4) Evenly Distributed</td>
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<tbody>
<tr>
<td>B. Best description of craniocaudal distribution of emphysema</td>
<td>D. Best description of craniocaudal distribution of interstitial process</td>
</tr>
<tr>
<td>(1) None</td>
<td>(1) None</td>
</tr>
<tr>
<td>(2) Upper lung predominant</td>
<td>(2) Upper lung predominant</td>
</tr>
<tr>
<td>(3) Lower lung predominant</td>
<td>(3) Lower lung predominant</td>
</tr>
<tr>
<td>(4) Diffuse</td>
<td>(4) Diffuse</td>
</tr>
<tr>
<td>(5) Superior segments of lower lobes predominantly involved</td>
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</table>
Please fill in a primary diagnosis and up to 3 secondary diagnoses from the Diagnosis List.

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<tr>
<th>Diagnosis List</th>
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<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>
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<tr>
<td>(5)  Nonspecific Interstitial Pneumonia</td>
</tr>
<tr>
<td>(6)  Desquamative Interstitial Pneumonia</td>
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<tr>
<td></td>
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<tr>
<td>(7)  Respiratory Bronchiolitis</td>
</tr>
<tr>
<td>(8)  Respiratory Bronchiolitis-Associated Interstitial Lung Disease</td>
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<tr>
<td>(9)  Lymphocytic Interstitial Pneumonitis</td>
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<tr>
<td>(10) Cryptogenic Organizing Pneumonia / Bronchiolitis</td>
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<tr>
<td>Obliterans Organizing Pneumonia</td>
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<tr>
<td>(11) Acute Interstitial Pneumonia / Diffuse Alveolar Damage</td>
</tr>
<tr>
<td>(12) Non-Diagnostic</td>
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<tr>
<td>(13) Fibrosis-Uncharacterized</td>
</tr>
<tr>
<td>(14) Primary Bronchogenic Carcinoma</td>
</tr>
<tr>
<td>(15) Lymphoma</td>
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</table>

Specify:

A. ICD-9  __________ . __________  ctdiag1sp
B. ICD-9  __________ . __________  ctdiag2sp
C. ICD-9  __________ . __________  ctdiag3sp
D. ICD-9  __________ . __________  ctdiag4sp
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 0 1 ___
   Month  Day  Year
   compl_dt
1. Date specimen obtained: ___-___-20___
   Month     Day     Year

Specimen Number: ____________________________
Visit Number: 01
**I. EVALUATION**

1. Final pathologic diagnosis:

<table>
<thead>
<tr>
<th>(1) Primary</th>
<th>(2) Secondary</th>
<th>(3) Secondary</th>
<th>(4) Secondary</th>
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<td>a. LTRC</td>
<td>b. ICD-9</td>
<td>a. LTRC</td>
<td>b. ICD-9</td>
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<tr>
<td>A. Overall</td>
<td>cpa11</td>
<td>cpa12</td>
<td>cpa13</td>
</tr>
<tr>
<td>B. Right Upper</td>
<td>cprul1</td>
<td>cprul2</td>
<td>cprul3</td>
</tr>
<tr>
<td>C. Right Middle</td>
<td>cprml1</td>
<td>cprml2</td>
<td>cprml3</td>
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<td>D. Right Lower</td>
<td>cprll1</td>
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<td>E. Left Upper</td>
<td>cplul1</td>
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<td>F. Lingula</td>
<td>cplgl1</td>
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<td>cplgl3</td>
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<td>G. Left Lower</td>
<td>cplll1</td>
<td>cplll2</td>
<td>cplll3</td>
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</table>

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. 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
II. ADMINISTRATIVE MATTERS

1. General Comments: ____________________________________________  
   ____________________________________________

2. Core Lab Pathologist:
   A. Signature: ______________________________________________  
      ______________________________________________
   B. LTRC Staff No. ___ ___ ___   ___ ___ ___                                           
      cert_no

3. Date Form Completed: ___ ___ ___ - ___ ___ - 2 0 1  
   Month   Day   Year  
   compl_dt
1. Date specimen obtained: ___ ___ ___ - ___ ___ - 2 0 1 ___ vis_dt
   Month           Day        Year
I. EVALUATION

<table>
<thead>
<tr>
<th>A. Primary</th>
<th>B. Secondary</th>
<th>C. Secondary</th>
<th>D. Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>lpdig1</td>
<td>lpdig2</td>
<td>lpdig3</td>
<td>lpdig4</td>
</tr>
</tbody>
</table>

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
50. Other

Specify: 
A. ICD-9 ___ ___ ___ . ___ ___ ldiag1sp
B. ICD-9 ___ ___ ___ . ___ ___ ldiag2sp
C. ICD-9 ___ ___ ___ . ___ ___ ldiag3sp
D. ICD-9 ___ ___ ___ . ___ ___ ldiag4sp
## II. ADMINISTRATIVE MATTERS

1. General Comments: 
   
   ____________________________________________ gen_cmnt

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

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

4. Date Form Completed: ____ ____ - ____ ____ - 2011 compl_dt
   
   Month Day Year
1. Date of final diagnosis: __________ - __________ - 201__ vis_dt
   Month       Day       Year
I. EVALUATION

1. Final Clinical Diagnosis.

<table>
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<tbody>
<tr>
<td>cldiag11</td>
<td></td>
<td></td>
<td>diag12sp</td>
<td>diag2sp</td>
<td>diag3sp</td>
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<tr>
<td>cldiag12</td>
<td></td>
<td></td>
<td>diag2sp</td>
<td>diag3sp</td>
<td>diag4sp</td>
</tr>
</tbody>
</table>

Please select up to 2 primary diagnoses (e.g. Emphysema as the 1st primary and Carcinoma, non-small cell as the 2nd primary) 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
(50) Other

A1. ICD-9  ________ . ________  diag11sp
A2. ICD-9  ________ . ________  diag12sp
B. ICD-9  ________ . ________  diag2sp
C. ICD-9  ________ . ________  diag3sp
D. ICD-9  ________ . ________  diag4sp
ID Number: 0 0 -  
Letter Code:  
Visit Number: 0 1

2. Has the six-week final diagnosis been referred to the patient’s primary care physician?  
   Yes  No  Necessary  
   (1 )  (2 )  (3 )  
   notifymd

II. ADMINISTRATIVE MATTERS

1. General Comments:  
   gen_cmnt

2. Principal or Co-Investigator:
   A. Signature:  
      pi62_sig
   B. LTRC Staff Number: ___ ___ ___ ___ ___ ___  
      pi62_no

3. Research Coordinator:
   A. Signature:  
      cert_sig
   B. LTRC Staff Number: ___ ___ ___ ___ ___ ___  
      cert_no

4. Date form completed: Month Day Year  
   compl_dt
   2 0 1
LUNG TISSUE RESEARCH CONSORTIUM (LTRC)
ADVERSE EVENT REPORT FORM

ID Number: 00 -
Letter Code: -

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

I. ADVERSE EVENT INFORMATION

1. A. Onset Date: ___ ______ - ______ - 20___
   Month   Day   Year
   ontm_hr ontm_mn
   vis_dt

B. Onset Time: ___ ___ : ___ ___
   end_dt

2. A. End Date: ___ ______ - ______ - 20___
   Month   Day   Year
   end_hr end_mn
   ongoing (1) ongoing
   end_dt

B. End Time: ___ ___ : ___ ___

3. Adverse Event Description: ______________________________________
   ae_desc

   A. Is this a serious adverse event? (1) (2) ae_ser
   Yes   No
   If this is a serious adverse event, please submit descriptive information
   (Form 71) and MedWatch 3500 to the DCC.

4. Body System(s) Affected
   Yes   No
   (1) (2)
   aeneuro
   aecard
   aeretend
   aepulm
   aediges
   aemusc
   aeimmun
   aeskin
   aeurogen
   aevent
   aeometab
   aenutr
   aeendo
   aeothr
   aeoth_sp

Specify __________________________

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

6. Outcome: Resolved (1) aeoutcm
   Ongoing (2)
   Died (3)
ID Number: 0 0 - 
Letter Code: 

Visit Number (Check only one):
01 □, 02 □, 03 □, 04 □, 05 □, 06 □, 07 □, 08 □, 09 □, 10 □, 11 □

7. Severity of Event: Mild (1) aesev
   Moderate (2)
   Severe (3)

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

II. ADMINISTRATIVE MATTERS

1. General Comments: ________________________________________ gen_cmnt

2. Principal or Co-Investigator (Signature required for SAE’s only):
   A. Signature: _____________________________________________ pi70_sig
   B. LTRC Staff No. ___ ___ ___ ___ ___ ___ pi70_no

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

4. Date Form Completed:   -   -   2   0   1 ___ compl_dt
   Month    Day    Year