ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
PFT - RETROSPECTIVE DATA

Form Completion Instructions:

Retrospective pulmomary function test data, data prior to the initial Registry visit, can be collected using this form on patients who have been entered into the Registry. Past pulmonary function test data should be recorded in the spaces provided. Be sure to start with the MOST recent pre-registry data. For each test section, any values unknown or tests not done should be indicated with a "9" in each of the dashes.

Make additional copies of this form as necessary. Be sure to keep copies of the form(s) for your files. Submit any hard copy tracings (those described for Form #03) that may be available.

The number of years of retrospective data collected will be at the discretion of the Principal Investigator at each Clinical Center. No additional monies will be paid for submission of this(ese) retrospective form(s).

If only 1 or 2 tests are being recorded, you may submit page 1 only, but be sure to indicate the name of the person completing the form and the physician signature at the bottom of page 1.

ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
Retrospective PFT Data Collection Form

To be completed only on patients entered into the Registry. Complete multiple forms if more than five sets of data. Submit hard copy tracings as for Form #03 if available.

1. Date form completed: F09Q01_fzd (fuzzed) ___ ___/ ___ ___/ ___ ___ (month day year)
2. Clinical Center code number: clinic (censored) ___ ___
3. Patient Registry ID: NewID (scrambled) ___ ___ ___ ___ ___
4. Patient name code: namecode (censored) ___ ___ ___ ___

Start with **most recent** pre-Registry PFT

5. Date of test: Testdate_fzd (fuzzed) ___ ___/ ___ ___/ ___ ___ (month day year)

Location: Location

___(1)Registry Clinical Center (code: center censored) ___(2)Local Physician's office

___(3)Other (Specify): Never entered ___(9)Unknown

Pre BD* FEV_1: Prefev1 (L) Pre BD* FVC: Prefvc (L)

Post BD* FEV_1: Postfev1 (L) Post BD* FVC: Postfvc (L)

TLC: TLC ___ ___(L) Hgb: HGB ___(g/dl)

DLCO: DLCO ___ ___(mlCO/min/mmHg)

6. Date of test: ___ ___/ ___ ___/ ___ ___ (month day year)

Location:

___(1)Registry Clinical Center (code: ___ ___) ___(2)Local Physician's office

___(3)Other (Specify): _____ ___(9)Unknown

Pre BD* FEV_1: ___.___ ___(L) Pre BD* FVC: ___.___ ___(L)

Post BD* FEV_1: ___.___ ___(L) Post BD* FVC: ___.___ ___(L)

TLC: ___ ___.___ ___(L) Hgb: ___ ___.___(g/dl)

DLCO: ___ ___.___ ___(mlCO/min/mmHg)

For variable names, see Question 5. Data recorded here entered as separate record in database.

*BD = Bronchodilator

White/Yellow: Clinical Coordinating Center, Pink: Clinical Center

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Patient Registry ID: ___ ___ ___ ___ ___
Date of Tests: ___ ___/ ___ ___/ ___ ___
month day year

See Question 5. Data recorded here entered as a separate record in database.

7. Date of test:..... ___ ___/ ___ ___/ ___ ___
month day year

Location:

___(1)Registry Clinical Center (code:___ ___) ___(2)Local Physician's office

___(3)Other (Specify): ___(9)Unknown

Pre BD* FEV_1: ___.___ ___(L) Pre BD* FVC: ___.___ ___(L)

Post BD* FEV_1: ___.___ ___(L) Post BD* FVC: ___.___ ___(L)

TLC: ___ ___.___ ___(L) Hgb: ___ ___.___(g/dl)

DLCO: ___ ___.___ ___(mlCO/min/mmHg)

See Question 5. Data recorded here entered as a separate record in database.

8. Date of test:..... ___ ___/ ___ ___/ ___ ___
month day year

Location:

___(1)Registry Clinical Center (code:___ ___) ___(2)Local Physician's office

___(3)Other (Specify): ___(9)Unknown

Pre BD* FEV_1: ___.___ ___(L) Pre BD* FVC: ___.___ ___(L)

Post BD* FEV_1: ___.___ ___(L) Post BD* FVC: ___.___ ___(L)

TLC: ___ ___.___ ___(L) Hgb: ___ ___.___(g/dl)

DLCO: ___ ___.___ ___(mlCO/min/mmHg)

See Question 5. Data recorded here entered as a separate record in database.

9. Date of test:..... ___ ___/ ___ ___/ ___ ___
month day year

Location:

___(1)Registry Clinical Center (code:___ ___) ___(2)Local Physician's office

___(3)Other (Specify): ___(9)Unknown

Pre BD* FEV_1: ___.___ ___(L) Pre BD* FVC: ___.___ ___(L)

Post BD* FEV_1: ___.___ ___(L) Post BD* FVC: ___.___ ___(L)

TLC: ___ ___.___ ___(L) Hgb: ___ ___.___(g/dl)

DLCO: ___ ___.___ ___(mlCO/min/mmHg)

***BD = Bronchodilator**

Form Completed By (Name): Never entered

Physician Signature: Never entered

White/Yellow: Clinical Coordinating Center, Pink: Clinical Center

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