


Lung Screening Study

**Spiral CT Screening Examination Quality Assurance Form (SCQ)**

<p><b>A. Screening Center:</b>  __ __ </p> <p><b>B. Date of QA Review:</b>  __ __  /  __ __  /  2 0 __ __   <small>Month Day Year</small></p> <p><b>C. Forms Processing: (CHECK BOXES AS STEPS ARE COMPLETED)</b></p> <table border="0"> <tr> <td><input type="checkbox"/> <b>Manual Review Completed</b></td> <td><b>Data Retrieval:</b>  <input type="checkbox"/> Attempted  <input type="checkbox"/> None required</td> <td><b>Final Disposition:</b>  <input type="checkbox"/> Final Complete (FCM)  <input type="checkbox"/> Final Incomplete (FIC)</td> </tr> </table>	<input type="checkbox"/> <b>Manual Review Completed</b>	<b>Data Retrieval:</b> <input type="checkbox"/> Attempted <input type="checkbox"/> None required	<b>Final Disposition:</b> <input type="checkbox"/> Final Complete (FCM) <input type="checkbox"/> Final Incomplete (FIC)	<div style="text-align: center;">                   SCQ             </div> <div style="border: 1px solid black; width: 100%; height: 100%; text-align: center; margin-top: 20px;">                 Participant ID Label             </div>
<input type="checkbox"/> <b>Manual Review Completed</b>	<b>Data Retrieval:</b> <input type="checkbox"/> Attempted <input type="checkbox"/> None required	<b>Final Disposition:</b> <input type="checkbox"/> Final Complete (FCM) <input type="checkbox"/> Final Incomplete (FIC)		

**D. SCT EXAMINATION FINDINGS (COMPLETED BY RADIOLOGIST)**

- 1. Radiologic Abnormality Noted:**
- No (GO TO PART E)
  - Yes (COMPLETE ITEM D-2, RECORD INFORMATION FOR EACH ABNORMALITY.)

**2. RECORD INFORMATION FOR EACH ABNORMALITY:**

Abn. #	Description of Abnormality	Size		Slice #	Location							
		Maximum Dimension (mm)	Maximum Perpendicular Dimension (mm)		Lobe (RECORD ALL THAT APPLY)							
	01=Spiculated non-calcified nodules/masses ≤ 3mm 02=Smooth non-calcified nodules/masses ≤ 3mm 03=Non-calcified nodules/masses > 3mm 04=Focal parenchymal opacification (consolidation or ground glass attenuation) 05=Endobronchial lesions 08=Granuloma(s) 17=Scarring/pulmonary fibrosis/honeycombing 18=Pleural fibrosis/pleural plaque 19=Pleural fluid 20=Bone/soft tissue lesion 21=Cardiac abnormality/ cardiomegaly/ congestive heart failure 22=COPD/emphysema/bullae 88= Other (SPECIFY)				01= right upper lobe 02= right middle lobe 03= right lower lobe 04= left upper lobe (excluding lingula) 05= lingula 06= left lower lobe 07= Diffuse 08= Not determined/Not applicable							
1	_ _	_ _ _	_ _ _	_ _	01	02	03	04	05	06	07	08
2	_ _	_ _ _	_ _ _	_ _	01	02	03	04	05	06	07	08
3	_ _	_ _ _	_ _ _	_ _	01	02	03	04	05	06	07	08
4	_ _	_ _ _	_ _ _	_ _	01	02	03	04	05	06	07	08
5	_ _	_ _ _	_ _ _	_ _	01	02	03	04	05	06	07	08
6	_ _	_ _ _	_ _ _	_ _	01	02	03	04	05	06	07	08

**E. SCT INTERPRETATION RESULTS (COMPLETED BY RADIOLOGIST)**

<p><b>1. Examination Result:</b></p> <input type="checkbox"/> Negative Screen –No Abnormalities (GO TO 3) <input type="checkbox"/> Inadequate (GO TO 2) <input type="checkbox"/> Positive Screen – Abnormalities Suggestive of Malignancy (GO TO 3) <input type="checkbox"/> Negative Screen –Significant Abnormalities (GO TO 3) <input type="checkbox"/> Negative Screen –Smooth, non-calcified nodules/masses ≤ 3 mm (GO TO 3) <input type="checkbox"/> Negative Screen –Other Minor Abnormalities (GO TO 3)	<p><b>2. Reason for Inadequate Exam:</b> (MARK ALL THAT APPLY)</p> <input type="checkbox"/> Poor image quality <input type="checkbox"/> Images lost <input type="checkbox"/> Other (SPECIFY) <hr/>
<p><b>3. Comments:</b></p> <input type="checkbox"/> No <input type="checkbox"/> Yes (SPECIFY) _____ _____ _____	<p><b>3. Radiologist ID:</b></p>  _ _ _ _  <hr/> Signature