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| --- |
| Site ID: |\_\_\_\_|\_\_\_\_| |
| Name of the investigator completing the form and signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date the form is completed: |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| PID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| Episode ID |\_\_\_\_|\_\_\_\_| |
| X-RAY FORM |

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| X-Ray |
| X-Ray request date | |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| On-site X-Ray | [ ]  Yes [ ]  No  |
| X-Ray type | [ ]  Digital [ ]  Analogue |
| X-Ray realisation date | |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| X-Ray reviewer | [ ]  Radiologist [ ]  Other doctor [ ]  Clinical officer[ ]  Nurse [ ]  OtherIf Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| X-Ray results:CavitiesEnlarged lymph nodesOpacitiesMiliary patternEffusion | [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No  |
| Date of X-ray result known by the clinicians | |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| Any comment: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |