|  |
| --- |
| 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 |

|  |  |
| --- | --- |
| 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  Other  If Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| X-Ray results:  Cavities  Enlarged lymph nodes  Opacities  Miliary pattern  Effusion | 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: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |