# Radiologist Data Collection Form

## I. Patient Identification

| | |
|---|---|
| **IAI Patient ID** | E M 2 0 -- ___ ___ ___ ___ -- ___ ___ ___ ___ |
| **Medical Record Number** | _____ (for site use only) |
| **Date of Birth** | ___ ___/ ___ ___ / ___ ___ ___ ___ |
| **Sex** | ☐ Male ☐ Female |

## II. CT Information

| | |
|---|---|
| **1. CT Date** | ___ ___ / ___ ___ / ___ ___ ___ ___ |
| **2. CT Time** | ___ ___:___ ___ (00:00-23:59) |

## III. Radiologist Data

| | |
|---|---|
| **1. Radiologist Name** | _____ |
| **2. Date this form completed** | ___ ___/ ___ ___ / ___ ___ ___ ___ |

## IV. CT Evaluation

| | |
|---|---|
| **1. Contrast Used:** | ☐ IV<br>☐ **Oral (Pt. Excluded)**<br>☐ **Oral & IV (Pt. Excluded)**<br>☐ **None (Pt. Excluded)** |
| **2. This CT was performed using collimation cuts of :** | ___ ___.___ ___ (mm) |
| **3. Do you see any abnormal findings which could affect appendix visualization (e.g. malrotation, Crohn's, evidence of prior surgery such as staples)?** | ☐ **Yes (Pt. Excluded)**<br>☐ No |
| **4. Do you see the appendix?** | ☐ Yes<br>☐ No |
| **4a. If "Yes", what image number(s) did you see the appendix?** | _____ - _____ (range) |
| **5. Is there any degree of fat completely surrounding the cecum?** | ☐ Yes<br>☐ No |
| **6. Did you find anything abnormal that you should notify the patient about?**<br>* If Yes, please review the CT report to verify the patient has not already been notified. If not, follow your institution's protocol for a new finding on reread. | ☐ Yes*<br>☐ No |

# RC Patient Screening Form

## I. Patient Identification

**IAI Patient ID** E M 2 0 -- ___ ___ ___ ___ -- ___ ___ ___ ___

**Medical Record Number** _____ (for site use only)

**Date of Birth** ___ ___/ ___ ___ / ___ ___ ___ ___

**Sex** ☐ Male ☐ Female

## II. Patient Screening

| | | |
|---|---|---|
| **1. First IAI CT Scan Date** | ___ ___ / ___ ___ / ___ ___ ___ ___<br>Answer all subsequent questions with patient information available on or before this date. | |
| **2. First IAI CT Scan Time** | ___ ___ :___ ___ (00:00-23:59) | |
| **3. Age in years at First CT** | _____ (Auto-filled by TrialDB. **If < 3 years, Pt. Excluded**) | |
| **4. Does your site collect data on past surgical history?** | ☐ Yes | ☐ No |
| **4a. If yes, was surgical history obtained?** | ☐ Yes | ☐ **No (Pt. excluded)** |
| **4b. If no, was medical history obtained?** | ☐ Yes | ☐ **No (Pt. excluded)** |
| **5. Did patient's history indicate appendix was taken out (appendectomy)?** | ☐ Yes | ☐ No |
| **6. Did the CT scan on date and time above use oral (PO) contrast?** | ☐ Yes | ☐ No |
| **6a. If "Yes", please have Site PI verify PO contrast was used.** | **Site PI Sign-off** _____<br>**(Pt. Excluded)** | |
| **7. Was weight recorded in medical records?** | ☐ Yes | ☐ **No weight found (Pt. excluded)** |
| **7a. If "Yes", please record weight:** | ___ ___ ___ . ___ | |
| **7b. Please record correct units for weight:** | ☐ kg | ☐ lbs |
| **7c. Method used to assess weight** | ☐ Actual weight | |
| | ☐ Estimate | |
| | ☐ Broselow weight | |