



INSTRUCTIONS FOR EXAM ITINERARY/CLINIC CHECK LIST CCL, VERSION 1.0 (QxQ)

I. GENERAL INSTRUCTIONS

The Clinical Check List is a source provided to make sure that every exam is completed during the patient's enrollment visit. The form is completed in unity with the participant exam.

This form is to be filled out at the baseline visit.

Header Information: The header information consists of key fields which uniquely identify each recorded instance of a form.

FORM DATE: Record date this is being completed. Select the date from the pop up calendar or type in the date in the space provided. Dates should be entered in the mm/dd/yyyy format.

INITIALS: Record the staff code of the person entering the data on this form. This code is assigned to each person at each site by the GIC. If you do not have a staff code and are collecting SPIROMICS data please contact the GIC in order to receive your own individual staff code.

II. GUIDELINES

The Clinical Itinerary has been created to lay out the visit flow for participants; including the order information should be collected, tests given and breaks for snacks and meals. This form is meant to be a helpful tool in successfully completing the baseline visit.

Enter the start time and end time as each procedure or data form is completed. Use the check box to mark items as complete.

Use the 'Comments/Notes' column to enter any important information that should be recorded regarding the procedure or form. If a procedure is not complete please carefully record details regarding the reason for omission in this section. Note that all procedures should be completed.

After each item is completed the staff person that completed the procedure and/or collected the data should record his/her initials in the 'Staff ID' column.

At the end of the form the staff person checking the information recorded on the CCL form and entering the CCL into the Data Management System should enter their staff code.