

CODIGO PACIENTE: \_\_\_\_\_

**Radiologic Interpretation Data Form**

Date of read: \_\_\_\_\_

Radiologist Name: \_\_\_\_\_

Radiologist Signature: \_\_\_\_\_

Patient code: \_\_\_\_\_

Patient gender:  male  female

Patient age: \_\_\_\_\_

**1. Type of film:**

AP  PA  Lateral from R  Lateral from L  Thoracic CT  
without contrast  Other: \_\_\_\_\_

2. Date of film: Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

3. Rotation: \_\_\_\_\_

4. Adequacy of inhalation: \_\_\_\_\_

	Site	a. Consolidation?	b. Cavitation?	c. Pneumatocele?	d. Atelectasis?
5	Right upper lobe	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
6	- anterior	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
7	- apical	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
8	- posterior	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
9	Right middle lobe	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
10	Right lower lobe	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
11	- superior	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
12	- basal	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
13	Left upper lobe	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
14	- anterior	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
15	- apical	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
16	- posterior	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
17	Lingula	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
18	Left lower lobe	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
19	- superior	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
20	- basal	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

21. Pleural effusion?  yes  no  
left?  small  medium  large  
right?  small  medium  large

La asociación de la frecuencia de la tos con la dinámica microbiológica de la tuberculosis en pacientes con tuberculosis pulmonar activa.

CODIGO PACIENTE: \_\_\_\_\_

22. Miliary spread?  yes  no

23. Pneumothorax?  yes  no

where and size: \_\_\_\_\_

24. Lymphadenopathy:  yes  no

which lymph nodes groups

hilar  mediastinal

25. Pericardial effusion?  yes  no

left?  small  medium  large

26. Bronchiectasis?  yes  no

where: \_\_\_\_\_

27. Fibrosis?  yes  no

where: \_\_\_\_\_

any retractions, deviations? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

28. Mediastinal thickening?  yes  no

29. Any tree-in-bud pattern? Where? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

30. Cavitation: For each cavity, please describe:

Cavity # 1:

location: \_\_\_\_\_

size (in mm) cephalic: \_\_\_\_\_

size (in mm) caudal: \_\_\_\_\_

size (in mm) anterior-posterior: \_\_\_\_\_

presence of air/ fluid level?:  yes  no

Cavity wall:  think  thick smooth nodular

Cavity Wall Thickness(in mm): \_\_\_\_\_

Cavity # 2:

location: \_\_\_\_\_

size (in mm) cephalic: \_\_\_\_\_

size (in mm) caudal: \_\_\_\_\_

size (in mm) anterior-posterior: \_\_\_\_\_

presence of air/ fluid level?:  yes  no

Cavity wall:  think  thick smooth nodular

Cavity Wall Thickness(in mm): \_\_\_\_\_

Cavity #3:

location: \_\_\_\_\_

size (in mm) cephalic: \_\_\_\_\_

size (in mm) caudal: \_\_\_\_\_

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CODIGO PACIENTE: \_\_\_\_\_

size (in mm) anterior-posterior: \_\_\_\_\_

presence of air/ fluid level?:  yes  no

Cavity wall:  think  thick  smooth  nodular

Cavity Wall Thickness(in mm): \_\_\_\_\_

Cavity # 4:

location: \_\_\_\_\_

size (in mm) cephalic: \_\_\_\_\_

size (in mm) caudal: \_\_\_\_\_

size (in mm) anterior-posterior: \_\_\_\_\_

presence of air/ fluid level?:  yes  no

Cavity wall:  think  thick  smooth  nodular

Cavity Wall Thickness(in mm): \_\_\_\_\_

Cavity # 5:

location: \_\_\_\_\_

size (in mm) cephalic: \_\_\_\_\_

size (in mm) caudal: \_\_\_\_\_

size (in mm) anterior-posterior: \_\_\_\_\_

presence of air/ fluid level?:  yes  no

Cavity wall:  think  thick  smooth  nodular

Cavity Wall Thickness(in mm): \_\_\_\_\_

More cavities?  yes: please use another sheet to describe  no

Other findings such as fractures, cardiac abnormalities, exudative / fibrotic densities, bronchogenic spread, mass-like lesions (calcified vs. non-calcified), please describe:

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31. Normal film?  yes  no