



## Bronchoscopy Interventional Registry

Patient Name: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Attending Name: \_\_\_\_\_

**This form is for internal purposes only. Once the data has been transferred into the AQUIRE Registry this form must be destroyed.**

**The patient name and medical record number, along with the system-generated patient ID, which will be generated when this record is entered into AQUIRE, should be recorded in the patient log-book.**

\* -Denotes required.

Demographic Information	
<b>Race:*</b> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<b>Sex:*</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
General Patient and Procedure Information	
<b>Site of service where the procedure took place*:</b> <input type="checkbox"/> Physician Office <input type="checkbox"/> Outpatient Hospital (length of stay under 24 hours) <input type="checkbox"/> Inpatient Hospital (length of stay over 24 hours) <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other (specify) _____	
<b>Patient age on the day of the procedure:*</b> ____	<b>Urgency of procedure:*</b> <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent <input type="checkbox"/> Elective
<b>Fellow's participation with the procedure:*</b> <input type="checkbox"/> A fellow did not participate in the procedure <input type="checkbox"/> A fellow participated in < 50% of the procedure <input type="checkbox"/> A fellow participated in > 50% of the procedure	
<b>First assistant assisting with the procedure:*</b> <input type="checkbox"/> Nurse <input type="checkbox"/> Respiratory therapist <input type="checkbox"/> Technician <input type="checkbox"/> Other (specify) _____	
<b>Is this the patient's first interventional procedure?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no</i> → Enter the date of the patient's first IP procedure _____	
SF6 D Questionnaire Pre-procedure	

**Was an SF6 D obtained?\***  Yes  No, patient was not capable of completing the SF6 D questionnaire  
 No, patient was capable of completing the SF6 D questionnaire, but did not  
*If yes* → complete the following questions by selecting the patient's responses to the SF6 D questionnaire  
*If no* → move on to the "Other Quality of Life Indicators"

---

**Physical Functioning:\***  Level 1: Your health does not limit you in vigorous activities  
 Level 2: Your health limits you a little in vigorous activities  
 Level 3: Your health limits you a little in moderate activities  
 Level 4: Your health limits you a lot in moderate activities  
 Level 5: Your health limits you a little in bathing and dressing

---

**Role Limitations:\***  Level 1: You have no problems with your work or other regular daily activities as a result of your physical health or any emotional problems  
 Level 2: You are limited in the kind of work or other activities as a result of your physical health  
 Level 3: You accomplish less than you would like as a result of emotional problems  
 Level 4: You are limited in the kind of work or other activities as a result of your physical health and accomplish less than you would like as a result of emotional problems

---

**Social Functioning:\***  Level 1: Your health limits your social activities none of the time  
 Level 2: Your health limits your social activities a little of the time  
 Level 3: Your health limits your social activities some of the time  
 Level 4: Your health limits your social activities most of the time  
 Level 5: Your health limits your social activities all of the time

---

**Pain:\***  Level 1: You have no pain  
 Level 2: You have pain but it does not interfere with your normal work (both outside the home and housework)  
 Level 3: You have pain that interferes with your normal work (both outside the home and housework) a little bit  
 Level 4: You have pain that interferes with your normal work (both outside the home and housework) moderately  
 Level 5: You have pain that interferes with your normal work (both outside the home and housework) quite a bit  
 Level 6: You have pain that interferes with your normal work (both outside the home and housework) extremely

---

**Mental Health:\***  Level 1: You feel tense or downhearted and low none of the time  
 Level 2: You feel tense or downhearted and low a little of the time  
 Level 3: You feel tense or downhearted and low some of the time  
 Level 4: You feel tense or downhearted and low most of the time  
 Level 5: You feel tense or downhearted and low all of the time

---

**Vitality:\***  Level 1: You have a lot of energy all of the time  
 Level 2: You have a lot of energy most of the time  
 Level 3: You have a lot of energy some of the time  
 Level 4: You have a lot of energy a little of the time  
 Level 5: You have a lot of energy none of the time

**Other Quality of Life Indicators**

---

**Was a Borg Score obtained?\***  Yes  Could not be obtained, patient was not capable  Was not obtained  
*If yes* → Indicate your patients modified Borg score  0-Nothing at all  0.5-Very, very slight  1-Very slight  
 2-Slight  3-Moderate  4-Somewhat severe  5- Severe  
 6  7-Very severe  8  9-Very, very severe  10-Maximal

<b>Were FEV1 and FVC obtained?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> Could not be obtained, patient was not capable <input type="checkbox"/> Was not obtained <i>If yes</i> → Indicate the patient's FEV1 percent of predicted numeric value (range 1-200) _____ <i>If yes</i> → Indicate the patient's FVC percent of predicted numeric value (range 1-200) _____	
<b>Zubrod score:*</b> <input type="checkbox"/> 0-normal activity, asymptomatic <input type="checkbox"/> 1-symptoms but fully ambulatory <input type="checkbox"/> 2- symptoms, but in bed >50% of the time <input type="checkbox"/> 3-Symptoms, but in bed >50% but <100% of the time <input type="checkbox"/> 4-bedridden <input type="checkbox"/> 5-moribund	
<b>ASA score:*</b> <input type="checkbox"/> 1- A completely healthy patient <input type="checkbox"/> 2- A patient with mild systemic disease <input type="checkbox"/> 3- A patient with severe systemic disease that is not incapacitating <input type="checkbox"/> 4- A patient with incapacitating disease that is a constant threat to life <input type="checkbox"/> 5- A moribund patient who is not expected to live 24 hours with or without surgery	<b>Was the ASA emergent?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Indicate any comorbidities the patient has:*</b> <input type="checkbox"/> CAD <input type="checkbox"/> COPD <input type="checkbox"/> CHF <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> HTN <input type="checkbox"/> Asthma <input type="checkbox"/> GERD <input type="checkbox"/> Renal failure, creatinine > 2, no hemodialysis <input type="checkbox"/> Renal failure, hemodialysis <input type="checkbox"/> Hematologic malignancy <input type="checkbox"/> None of the above	
<b>Indicate if the patient is using any of the following medications:*</b> <input type="checkbox"/> Inhaled steroids <input type="checkbox"/> Inhaled beta agonist <input type="checkbox"/> Inhaled anticholinergics <input type="checkbox"/> None of the above	

<b>Bleeding/Risk/Labs</b>	
<b>Platelets:*</b> <input type="checkbox"/> ≤ 50,000 <input type="checkbox"/> 50,001-100,000 <input type="checkbox"/> > 100,000 <input type="checkbox"/> Test not performed	<b>INR:*</b> <input type="checkbox"/> <1.5 <input type="checkbox"/> 1.5-2 <input type="checkbox"/> >2 <input type="checkbox"/> Test not performed
<b>Did the patient take clopidogrel within 96 hours of the procedure?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Is the patient taking a medication besides clopidogrel or have a disease that increases the risk of bleeding?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Lifestyle</b>	
<b>Patient's tobacco use in the form of cigarettes:*</b> <input type="checkbox"/> Current use of cigarettes <input type="checkbox"/> Prior use of cigarettes <input type="checkbox"/> Never used cigarettes <i>If current or prior use</i> → Indicate pack years of patient's tobacco use in the form of cigarettes ____	

<b>Malignant Indication for Procedure</b>	
<i>(Skip this section if the indication for the procedure is "non-malignant")</i>	
<b>Date of diagnosis for malignancy, if unknown approximate the date:*</b> _____	
<b>Malignant disease indication for the procedure:*</b> <input type="checkbox"/> Non-small cell lung cancer- squamous <input type="checkbox"/> Non-small cell lung cancer- adenocarcinoma <input type="checkbox"/> Non-small cell lung cancer- non-specified (undifferentiated) <input type="checkbox"/> Small cell lung cancer <input type="checkbox"/> Metastatic to the lung originating from a solid tumor of the breast <input type="checkbox"/> Metastatic to the lung originating from a renal solid tumor <input type="checkbox"/> Dysplasia / Metaplasia <input type="checkbox"/> Sarcoma <input type="checkbox"/> Metastatic to the lung originating from a solid tumor of the colon <input type="checkbox"/> Carcinoma in situ <input type="checkbox"/> Carcinoid - atypical <input type="checkbox"/> Metastatic to the lung originating from a melanoma solid tumor <input type="checkbox"/> Metastatic to the lung originating from a solid tumor of the thyroid <input type="checkbox"/> Carcinoid – typical <input type="checkbox"/> Metastatic to the lung originating from other solid tumor <input type="checkbox"/> Metastatic to the lung from a hematological origin <input type="checkbox"/> Adenocystic <input type="checkbox"/> Large cell – neuroendocrine <input type="checkbox"/> Tracheoesophageal fistula, malignant <input type="checkbox"/> Mucoepidermoid <input type="checkbox"/> Other lung primary (specify) _____  <i>If tracheoesophageal fistula, malignant</i> → Indicate the primary site of the tracheoesophageal fistula: <input type="checkbox"/> Trachea <input type="checkbox"/> Left main <input type="checkbox"/> Right main <input type="checkbox"/> Carina	

<b>Type of Obstruction</b>
----------------------------

<p><b>Indicate the type of obstruction leading to the intervention in the trachea*</b> <input type="checkbox"/> Trachea was not involved</p> <p><input type="checkbox"/> Intrinsic obstruction</p> <p><input type="checkbox"/> Extrinsic obstruction</p> <p><input type="checkbox"/> Mixed obstruction</p>
<p><b>Indicate the type of obstruction leading to the intervention in the left main stem*</b> <input type="checkbox"/> Left main stem was not involved</p> <p><input type="checkbox"/> Intrinsic obstruction</p> <p><input type="checkbox"/> Extrinsic obstruction</p> <p><input type="checkbox"/> Mixed obstruction</p>
<p><b>Indicate the type of obstruction leading to the intervention in the right main stem*</b> <input type="checkbox"/> Right main stem was not involved</p> <p><input type="checkbox"/> Mixed obstruction</p> <p><input type="checkbox"/> Intrinsic obstruction</p> <p><input type="checkbox"/> Extrinsic obstruction</p>
<p><b>Indicate the type of obstruction leading to the intervention in the bronchus intermedius*</b> <input type="checkbox"/> Bronchus intermedius wasn't involved</p> <p><input type="checkbox"/> Intrinsic obstruction</p> <p><input type="checkbox"/> Extrinsic obstruction</p> <p><input type="checkbox"/> Mixed obstruction</p>
<p><b>Indicate the type of obstruction leading to the intervention in a lobar takeoff*</b> <input type="checkbox"/> A lobar takeoff was not involved</p> <p><input type="checkbox"/> Intrinsic obstruction</p> <p><input type="checkbox"/> Extrinsic obstruction</p> <p><input type="checkbox"/> Mixed obstruction</p>

<p><b>Non-malignant Indication for Procedure</b></p> <p><b>Non-malignant indication for the intervention:*</b></p> <p><input type="checkbox"/> Postintubation tracheal stenosis, complex (any malacia or length &gt; 1 cm) <input type="checkbox"/> Postintubation tracheal stenosis, web (&lt; 1 cm) <input type="checkbox"/> Tracheobronchomalacia</p> <p><input type="checkbox"/> Posttracheostomy A-shaped stenosis <input type="checkbox"/> Idiopathic subglottic stenosis with cricoid involvement <input type="checkbox"/> Tracheoesophageal fistula, benign <input type="checkbox"/> Foreign body</p> <p><input type="checkbox"/> Subglottic stenosis with cricoid involvement due to other disease <input type="checkbox"/> Subglottic stenosis without cricoid involvement due to other disease <input type="checkbox"/> Broncholith</p> <p><input type="checkbox"/> Removal of one way valve(s) or other implant(s) from a previous emphysema treatment <input type="checkbox"/> Tracheal or bronchial stenosis due to other benign disease</p> <p><input type="checkbox"/> Anatomic extrinsic compression (vascular rings, bone, thyroid, other) <input type="checkbox"/> Stent removal, which was placed during a previous procedure <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Adjustment of stent, which was placed during a previous procedure <input type="checkbox"/> Emphysema treatment <input type="checkbox"/> Other benign disease (specify) _____</p> <p><i>If tracheobronchomalacia</i> → Indicate the most proximal location of the tracheobronchomalacia <input type="checkbox"/> Trachea <input type="checkbox"/> Left main <input type="checkbox"/> Right main <input type="checkbox"/> Carina</p> <p><i>If tracheoesophageal fistula</i> → Indicate the most proximal location of the <i>tracheoesophageal fistula</i> <input type="checkbox"/> Trachea <input type="checkbox"/> Left main <input type="checkbox"/> Right main <input type="checkbox"/> Carina</p> <p><i>If tracheal or bronchial stenosis</i> → Indicate the most proximal location of the tracheal or bronchial stenosis: <input type="checkbox"/> Trachea <input type="checkbox"/> Left main <input type="checkbox"/> Right main</p> <p><input type="checkbox"/> Bronchus intermedius <input type="checkbox"/> Lobar <input type="checkbox"/> Carina</p> <p><i>If tracheal or bronchial stenosis</i> → Indicate the type of disease associated with tracheal or bronchial stenosis: <input type="checkbox"/> Postradiation stenosis <input type="checkbox"/> Wegener's disease</p> <p><input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Relapsing polychondritis</p> <p><input type="checkbox"/> Other (specify) _____</p>
--

<p><b>Removal of One Way Valve(s) or Other Implant(s) from a Previous Emphysema Treatment</b>  <i>(Skip this section if the non-malignant indication was NOT removal of one way valve(s) or other implant(s))</i></p>
---

<b>Indicate the reason for removal of a one way valve(s) or other implant(s) from previous emphysema treatment:</b> <input type="checkbox"/> Lack of efficacy or improvement after treatment <input type="checkbox"/> Active infection at valve or distal to valve <input type="checkbox"/> Valve migration- valve was found within target bronchus <input type="checkbox"/> Valve migration- valve was found outside target bronchus <input type="checkbox"/> Valve migration- valve was found within target lobe <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Valve migration- valve was found outside target lobe <input type="checkbox"/> Persistent hemoptysis <input type="checkbox"/> Emphyema <input type="checkbox"/> Respiratory failure <input type="checkbox"/> Incorrect placement <input type="checkbox"/> Granulation tissue adjacent to the valves <input type="checkbox"/> Increased dyspnea <input type="checkbox"/> Continuing COPD exacerbation <input type="checkbox"/> Other (specify) _____	
<b>Date of original one way valve(s), implant(s) placement:</b> _____	
<b>How many one way valve(s) or other implant(s) were placed during the previous emphysema treatment? (range 1-15)</b>	<b>How many one way valve(s) or other implant(s) were removed during this procedure? (range 1-15)</b> _____
<b>Indicate location(s) where one way valve(s) or other implant(s) was placed during the previous emphysema treatment:</b> <input type="checkbox"/> RUL; Apical segment / B1 <input type="checkbox"/> RUL; Posterior segment / B2 <input type="checkbox"/> RUL; Anterior segment / B3 <input type="checkbox"/> RML; Lateral segment / B4 <input type="checkbox"/> RML; Medial segment / B5 <input type="checkbox"/> RLL; Superior segment / B6 <input type="checkbox"/> RLL; Medial basal segment / B7 <input type="checkbox"/> RLL; Anterior basal segment / B8 <input type="checkbox"/> RLL; Lateral basal segment / B9 <input type="checkbox"/> RLL; Posterior basal segment / B10 <input type="checkbox"/> LUL; Apical posterior segment / B1 2 <input type="checkbox"/> LUL; Anterior segment / B3 <input type="checkbox"/> Lingula; Superior segment / B4 <input type="checkbox"/> Lingula; Inferior segment / B5 <input type="checkbox"/> LLL; Superior segment / B6 <input type="checkbox"/> LLL; Anteromedial basal segment / B7 8 <input type="checkbox"/> LLL; Lateral basal segment / B9 <input type="checkbox"/> LLL; Posterior basal segment / B10	
<b>Indicate location(s) where one way valve(s) or other implant(s) was removed during this procedure:</b> <input type="checkbox"/> RUL; Apical segment / B1 <input type="checkbox"/> RUL; Posterior segment / B2 <input type="checkbox"/> RUL; Anterior segment / B3 <input type="checkbox"/> RML; Lateral segment / B4 <input type="checkbox"/> RML; Medial segment / B5 <input type="checkbox"/> RLL; Superior segment / B6 <input type="checkbox"/> RLL; Medial basal segment / B7 <input type="checkbox"/> RLL; Anterior basal segment / B8 <input type="checkbox"/> RLL; Lateral basal segment / B9 <input type="checkbox"/> RLL; Posterior basal segment / B10 <input type="checkbox"/> LUL; Apical posterior segment / B1 2 <input type="checkbox"/> LUL; Anterior segment / B3 <input type="checkbox"/> Lingula; Superior segment / B4 <input type="checkbox"/> Lingula; Inferior segment / B5 <input type="checkbox"/> LLL; Superior segment / B6 <input type="checkbox"/> LLL; Anteromedial basal segment / B7 8 <input type="checkbox"/> LLL; Lateral basal segment / B9 <input type="checkbox"/> LLL; Posterior basal segment / B10	
<b>Indicate the type of one way valve(s) or other implant(s) that was removed during this procedure:</b> <input type="checkbox"/> Bronchus <div style="text-align: right; margin-right: 50px;"> <input type="checkbox"/> Emphasys  <input type="checkbox"/> Pulmonx  <input type="checkbox"/> Spiration  <input type="checkbox"/> Other (specify) _____ </div>	

<b>Stent Removal Which Was Placed During a Previous Procedure</b> <i>(Skip this section if the non-malignant indication was NOT stent removal which was placed during a previous procedure)</i>
<b>Indicate date of original stent placement</b> _____
<b>Indicate the location(s) where the stent(s) which was placed during a previous procedure was removed from:</b> <input type="checkbox"/> Trachea <input type="checkbox"/> Left main <input type="checkbox"/> Right main <input type="checkbox"/> Y-Shaped <input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL
<b>Indicate the type of stent(s) removed, which was placed during the previous procedure:</b> <input type="checkbox"/> Ultraflex Covered Stent (Boston Scientific) <input type="checkbox"/> Ultraflex Uncovered Stent (Boston Scientific) <input type="checkbox"/> Aero Tracheobronchial Stent (Alveolus) <input type="checkbox"/> Silicone Tube Stent (Bryan) <input type="checkbox"/> Silicone Tube Stent (Hood) <input type="checkbox"/> Silicone Tube Stent (Novatech) <input type="checkbox"/> Y-shaped Silicone (Bryan) <input type="checkbox"/> Y-shaped Silicone (Hood) <input type="checkbox"/> Y-shaped Silicone (Novatech) <input type="checkbox"/> Polyflex Stent (Boston Scientific) <input type="checkbox"/> Dynamic Stent (Boston Scientific) <input type="checkbox"/> BonaStent (Boston Scientific) <input type="checkbox"/> BonaStent Metal (Boston Scientific) <input type="checkbox"/> Eco-Stent (Leufen) <input type="checkbox"/> Eco-Y-Stent (Leufen) <input type="checkbox"/> Hanaro Stent (MTW) <input type="checkbox"/> Micro-Tech Covered Straight Stent (Leufen) <input type="checkbox"/> Micro-Tech Covered Y-Stent (Leufen) <input type="checkbox"/> Niti-S Covered Straight Stent (Pyramed) <input type="checkbox"/> Other (specify) _____
<b>Indicate the reason for removing the stent(s) which was placed during a previous procedure:</b> <input type="checkbox"/> Stent was out of position <input type="checkbox"/> Granulation of tissue <input type="checkbox"/> Refractory infection <input type="checkbox"/> Stent fracture <input type="checkbox"/> Tumor overgrowth <input type="checkbox"/> Other (specify) _____

<b>Anesthesia</b>
-------------------

<b>Deepest level of anesthesia performed:*</b> <input type="checkbox"/> Local <input type="checkbox"/> Moderate <input type="checkbox"/> Deep <input type="checkbox"/> General		<b>Who administered the sedation to the patient?*</b> <input type="checkbox"/> Anesthesiologist <input type="checkbox"/> Bronchoscopist <input type="checkbox"/> Nurse <input type="checkbox"/> CRNA <input type="checkbox"/> Fellow <input type="checkbox"/> Other (specify) _____	
<b>Was paralysis used?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Was ventilation used?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes</i> → Indicate method of ventilation: <input type="checkbox"/> Volume cycled, pressure control, or pressure support <input type="checkbox"/> High frequency jet ventilation <input type="checkbox"/> Low frequency jet ventilation	
<b>Indicate type of bronchoscope used:*</b> <input type="checkbox"/> Flexible <input type="checkbox"/> Rigid <input type="checkbox"/> Both flexible and rigid		<b>Indicate approach used:*</b> <input type="checkbox"/> Nasal <input type="checkbox"/> Oral <input type="checkbox"/> ETT <input type="checkbox"/> LMA <input type="checkbox"/> Tracheotomy tube	

<b>Procedure Time</b> <i>(Use the 24-hour clock)</i>	
<b>Indicate the time of induction:*</b> _____	<b>Indicate time of scope insertion:*</b> _____
<b>Indicate time of scope removal:*</b> _____	<b>Indicate time patient was removed from the procedure room after the bronchoscopy:*</b> _____

<b>Dilation</b>
<b>If dilation was performed, indicate the following:*</b> <input type="checkbox"/> Dilation was not performed <input type="checkbox"/> Performed with balloon dilation <input type="checkbox"/> Performed with mechanical dilation <input type="checkbox"/> Both balloon dilation and mechanical dilation

<b>Stent 1 Placement</b> <i>(Skip this section if a stent was not placed during this procedure)</i>
<b>Indicate the type of stent placed:*</b> <input type="checkbox"/> Ultraflex Covered Stent (Boston Scientific) <input type="checkbox"/> Ultraflex Uncovered Stent (Boston Scientific) <input type="checkbox"/> Aero Tracheobronchial Stent (Alveolus) <input type="checkbox"/> Silicone Tube Stent (Bryan) <input type="checkbox"/> Silicone Tube Stent (Hood) <input type="checkbox"/> Silicone Tube Stent (Novatech) <input type="checkbox"/> Y-shaped Silicone (Bryan) <input type="checkbox"/> Y-shaped Silicone (Hood) <input type="checkbox"/> Y-shaped Silicone (Novatech) <input type="checkbox"/> Polyflex Stent (Boston Scientific) <input type="checkbox"/> Dynamic Stent (Boston Scientific) <input type="checkbox"/> BonaStent (Boston Scientific) <input type="checkbox"/> BonaStent Metal (Boston Scientific) <input type="checkbox"/> Eco-Stent (Leufen) <input type="checkbox"/> Eco-Y-Stent (Leufen) <input type="checkbox"/> Hanaro Stent (MTW) <input type="checkbox"/> Micro-Tech Covered Straight Stent (Leufen) <input type="checkbox"/> Micro-Tech Covered Y-Stent (Leufen) <input type="checkbox"/> Niti-S Covered Straight Stent (Pyramed) <input type="checkbox"/> Other (specify name and local distributor) _____
<b>Specify location(s) of stent 1:*</b> <i>If straight stent</i> → <input type="checkbox"/> Trachea <input type="checkbox"/> Left main <input type="checkbox"/> Right main <input type="checkbox"/> RUL <input type="checkbox"/> RML <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LLL <i>If Y-shaped stent</i> → <input type="checkbox"/> Full Y-shaped stent at main carina <input type="checkbox"/> Single arm left sided Y-shaped stent <input type="checkbox"/> Single arm right sided Y-shaped stent
<b>Indicate any problems, which occurred as a result of the stent 1's placement or deployment:*</b> <input type="checkbox"/> There were no mechanical problems associated with stent placement or deployment <input type="checkbox"/> There was a mechanical problem with proper stent opening <input type="checkbox"/> There was a problem with stent positioning <input type="checkbox"/> Initial stent was inappropriately sized <input type="checkbox"/> Other (specify) _____

Was the problem with stent 1 corrected? \*  Corrected  Unable to correct

### Stent 2 Placement

*(Skip this section if zero or one stent was placed during this procedure)*

#### Indicate the type of stent placed:\*

- Ultraflex Covered Stent (Boston Scientific)  Ultraflex Uncovered Stent (Boston Scientific)  Aero Tracheobronchial Stent (Alveolus)  
 Silicone Tube Stent (Bryan)  Silicone Tube Stent (Hood)  Silicone Tube Stent (Novatech)  Y-shaped Silicone (Bryan)  Y-shaped Silicone (Hood)  
 Y-shaped Silicone (Novatech)  Polyflex Stent (Boston Scientific)  Dynamic Stent (Boston Scientific)  BonaStent (Boston Scientific)  
 BonaStent Metal (Boston Scientific)  Eco-Stent (Leufen)  Eco-Y-Stent (Leufen)  Hanaro Stent (MTW)  
 Micro-Tech Covered Straight Stent (Leufen)  Micro-Tech Covered Y-Stent (Leufen)  Niti-S Covered Straight Stent (Pyramed)  
 Other (specify name and local distributor) \_\_\_\_\_

#### Specify location(s) of stent 2:\*

*If straight stent* →  Trachea  Left main  Right main  RUL  RML  RLL  LUL  LLL

*If Y-shaped stent* →  Full Y-shaped stent at main carina  Single arm left sided Y-shaped stent  Single arm right sided Y-shaped stent

#### Indicate any problems, which occurred as a result of the stent 2's placement or deployment:\*

- There were no mechanical problems associated with stent placement or deployment  There was a mechanical problem with proper stent opening  
 There was a problem with stent positioning  Initial stent was inappropriately sized  Other (specify) \_\_\_\_\_

Was the problem with stent 2 corrected? \*  Corrected  Unable to correct

### Stent 3 Placement

*(Skip this section if zero, one, or two stent(s) was placed during this procedure)*

#### Indicate the type of stent placed:\*

- Ultraflex Covered Stent (Boston Scientific)  Ultraflex Uncovered Stent (Boston Scientific)  Aero Tracheobronchial Stent (Alveolus)  
 Silicone Tube Stent (Bryan)  Silicone Tube Stent (Hood)  Silicone Tube Stent (Novatech)  Y-shaped Silicone (Bryan)  Y-shaped Silicone (Hood)  
 Y-shaped Silicone (Novatech)  Polyflex Stent (Boston Scientific)  Dynamic Stent (Boston Scientific)  BonaStent (Boston Scientific)  
 BonaStent Metal (Boston Scientific)  Eco-Stent (Leufen)  Eco-Y-Stent (Leufen)  Hanaro Stent (MTW)  
 Micro-Tech Covered Straight Stent (Leufen)  Micro-Tech Covered Y-Stent (Leufen)  Niti-S Covered Straight Stent (Pyramed)  
 Other (specify name and local distributor) \_\_\_\_\_

#### Specify location(s) of stent 3:\*

*If straight stent* →  Trachea  Left main  Right main  RUL  RML  RLL  LUL  LLL

*If Y-shaped stent* →  Full Y-shaped stent at main carina  Single arm left sided Y-shaped stent  Single arm right sided Y-shaped stent

#### Indicate any problems, which occurred as a result of the stent 3's placement or deployment:\*

- There were no mechanical problems associated with stent placement or deployment  There was a mechanical problem with proper stent opening  
 There was a problem with stent positioning  Initial stent was inappropriately sized  Other (specify) \_\_\_\_\_

Was the problem with stent 3 corrected? \*  Corrected  Unable to correct

### Stent Removal Which Was Placed During This Procedure

*(Skip this section if a stent was NOT removed that was placed during this procedure)*

**What type of stent was placed, which required removal?\***

Ultraflex Covered Stent (Boston Scientific)  
 Ultraflex Uncovered Stent (Boston Scientific)  
 Aero Tracheobronchial Stent (Alveolus)  
 Silicone Tube Stent (Bryan)  
 Silicone Tube Stent (Hood)  
 Silicone Tube Stent (Novatech)  
 Y-shaped Silicone (Bryan)  
 Y-shaped Silicone (Hood)  
 Y-shaped Silicone (Novatech)  
 Polyflex Stent (Boston Scientific)  
 Dynamic Stent (Boston Scientific)  
 BonaStent (Boston Scientific)  
 BonaStent Metal (Boston Scientific)  
 Eco-Stent (Leufen)  
 Eco-Y-Stent (Leufen)  
 Hanaro Stent (MTW)  
 Micro-Tech Covered Straight Stent (Leufen)  
 Micro-Tech Covered Y-Stent (Leufen)  
 Niti-S Covered Straight Stent (Pyramed)  
 Other (specify name and local distributor) \_\_\_\_\_

**Indicate the reason why the stent was placed then removed:\***

Stent was out of position  
 Stent fracture  
 Stent was wrong size  
 Stent failed to open properly  
 Other (specify) \_\_\_\_\_

**Emphysema Intervention**  
*(Skip this section if emphysema intervention was not performed)*

**Indicate the emphysema intervention that was performed:\***  
 Intrabronchial valve  
 Airway bypass  
 Other (specify) \_\_\_\_\_

**Who manufactured the emphysema treatment?\***  
 Aeris  
 Broncus  
 Emphasys  
 Pneumrx  
 Pulmonx  
 Spiration  
 Uptake  
 Other

**Indicate location(s) where the valve(s) or other implant(s) were placed for the emphysema treatment:\***

RUL; Apical segment / B1  
 RUL; Posterior segment / B2  
 RUL; Anterior segment / B3  
 RML; Lateral segment / B4  
 RML; Medial segment / B5  
 RLL; Superior segment / B6  
 RLL; Medial basal segment / B7  
 RLL; Anterior basal segment / B8  
 RLL; Lateral basal segment / B9  
 RLL; Posterior basal segment / B10  
 LUL; Apical posterior segment / B1 2  
 LUL; Anterior segment / B3  
 Lingula; Superior segment / B4  
 Lingula; Inferior segment / B5  
 LLL; Superior segment / B6  
 LLL; Anteromedial basal segment / B7 8  
 LLL; Lateral basal segment / B9  
 LLL; Posterior basal segment / B10

**Indicate any mechanical problems, which occurred as a result of valve/implant placement or deployment:\***

There were no mechanical problems associated with valve/implant placement or deployment  
 There was a mechanical problem with proper valve/implant opening  
 There was a mechanical problem with valve/implant positioning  
 Other (specify) \_\_\_\_\_

**Success of the Procedure**

**Subjectively rate the technical success of the procedure performed \***

Completely successful  
 More than 50% successful  
 Less than 50% successful  
 Completely unsuccessful

**Complications within 1 Hour**  
*(Skip this section if complications did not occur within 1 hour of the procedure)*  
Indicate any complications that occurred within 1 hour of the procedure

<b>Bleeding*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pneumothorax:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes → Indicate intervention for pneumothorax</i> <input type="checkbox"/> Aspiration <input type="checkbox"/> Chest Tube <input type="checkbox"/> Observation	
<b>Clinically Significant airway injury:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Refractory Hypoxia (&gt; 1 min, less than 90% saturation despite supplemental oxygen:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Unexpected Hypotension:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Cardiac Arrest:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Arrhythmia:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes → Indicate type:</i> <input type="checkbox"/> AFib/Aflutter <input type="checkbox"/> V-Tach <input type="checkbox"/> V-Fib <input type="checkbox"/> Other (specify) _____

<b>Unexpected respiratory failure requiring intubation or ventilation:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Indicate any adverse events that occurred as a result of the complication:*</b> <input type="checkbox"/> There were no adverse events associated with the complication <input type="checkbox"/> Extended hospitalization <input type="checkbox"/> Intervention to prevent permanent impairment or damage <input type="checkbox"/> Life-threatening condition <input type="checkbox"/> Disability <input type="checkbox"/> Death	
<b>Can you attribute the complication to any portion of the procedure:*</b> <input type="checkbox"/> Ablative therapy <input type="checkbox"/> Ventilation <input type="checkbox"/> Anesthesia <input type="checkbox"/> Stent placement <input type="checkbox"/> Stent removal <input type="checkbox"/> Patient host factor <input type="checkbox"/> Sampling <input type="checkbox"/> Intubation <input type="checkbox"/> Valve removal <input type="checkbox"/> Valve placement <input type="checkbox"/> Other (specify) _____	<b>Was the complication resolved?*</b> <input type="checkbox"/> Yes, the complication was stabilized <input type="checkbox"/> Yes, the complication was reversed <input type="checkbox"/> No, the complication was not resolved

<b>Complications within 1-24 Hours</b> (Skip this section if complications did not occur within 1 -24 hours of the procedure) Indicate any complications that occurred within 1-24 hours of the procedure		
<b>Bleeding*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pneumothorax:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes → Indicate intervention for pneumothorax</i> <input type="checkbox"/> Aspiration <input type="checkbox"/> Chest Tube <input type="checkbox"/> Observation	
<b>Clinically Significant airway injury:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Refractory Hypoxia (&gt; 1 min, less than 90% saturation despite supplemental oxygen:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Unexpected Hypotension:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Cardiac Arrest:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Arrhythmia:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes → Indicate type:</i> <input type="checkbox"/> AFib/Aflutter <input type="checkbox"/> V-Tach <input type="checkbox"/> V-Fib <input type="checkbox"/> Other (specify) _____
<b>Unexpected respiratory failure requiring intubation or ventilation:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Indicate any adverse events that occurred as a result of the complication:*</b> <input type="checkbox"/> There were no adverse events associated with the complication <input type="checkbox"/> Extended hospitalization <input type="checkbox"/> Intervention to prevent permanent impairment or damage <input type="checkbox"/> Life-threatening condition <input type="checkbox"/> Disability <input type="checkbox"/> Death		
<b>Can you attribute the complication to any portion of the procedure:*</b> <input type="checkbox"/> Ablative therapy <input type="checkbox"/> Ventilation <input type="checkbox"/> Anesthesia <input type="checkbox"/> Stent placement <input type="checkbox"/> Stent removal <input type="checkbox"/> Patient host factor <input type="checkbox"/> Sampling <input type="checkbox"/> Intubation <input type="checkbox"/> Valve removal <input type="checkbox"/> Valve placement <input type="checkbox"/> Other (specify) _____	<b>Was the complication resolved?*</b> <input type="checkbox"/> Yes, the complication was stabilized <input type="checkbox"/> Yes, the complication was reversed <input type="checkbox"/> No, the complication was not resolved	

<b>Level of Care</b>	
<b>Did an unexpected increase in the level of care occur as a result of the procedure? *</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes → Indicate reason for unexpected increase in the level of care*</i> <input type="checkbox"/> Complication <input type="checkbox"/> Additional diagnostic or treatment procedure required <input type="checkbox"/> Other (specify) _____	
<b>Level of care pre-procedure:</b> <input type="checkbox"/> Outpatient <input type="checkbox"/> Floor <input type="checkbox"/> Step-down unit <input type="checkbox"/> Intensive care unit <input type="checkbox"/> Emergency department	<b>Level of care post-procedure:</b> <input type="checkbox"/> Outpatient <input type="checkbox"/> Floor <input type="checkbox"/> Step-down unit <input type="checkbox"/> Intensive care unit <input type="checkbox"/> Emergency department <input type="checkbox"/> Patient expired

<b>30 Day Follow-Up</b> (Skip this section if death did NOT occur within 30 days of the procedure)	
<b>Date of death, if unknown approximate date:*</b> _____	
<b>Did death occur within 1 hour of the procedure?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Was mortality procedure-related?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Was mortality related to airway compromise?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Was mortality related to underlying lung disease?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

### SF6 D Questionnaire Post-procedure

**Was an SF6 D obtained within 30 days of the procedure (+ or – 2 weeks)?\***  Yes

No, patient was not capable of completing the SF6 D

No, patient was able to complete the SF6 D, but did not

*If yes* → complete the following questions by selecting the patient’s responses to the SF6 D questionnaire

*If no* → move on to the “Therapeutic Outcomes of Procedure”

**Physical Functioning:\***  Level 1: Your health does not limit you in vigorous activities

Level 2: Your health limits you a little in vigorous activities

Level 3: Your health limits you a little in moderate activities

Level 4: Your health limits you a lot in moderate activities

Level 5: Your health limits you a little in bathing and dressing

**Role Limitations:\***  Level 1: You have no problems with your work or other regular daily activities as a result of your physical health or any emotional problems

Level 2: You are limited in the kind of work or other activities as a result of your physical health

Level 3: You accomplish less than you would like as a result of emotional problems

Level 4: You are limited in the kind of work or other activities as a result of your physical health and accomplish less than you would like as a result of emotional problems

**Social Functioning:\***  Level 1: Your health limits your social activities none of the time

Level 2: Your health limits your social activities a little of the time

Level 3: Your health limits your social activities some of the time

Level 4: Your health limits your social activities most of the time

Level 5: Your health limits your social activities all of the time

**Pain:\***  Level 1: You have no pain

Level 2: You have pain but it does not interfere with your normal work (both outside the home and housework)

Level 3: You have pain that interferes with your normal work (both outside the home and housework) a little bit

Level 4: You have pain that interferes with your normal work (both outside the home and housework) moderately

Level 5: You have pain that interferes with your normal work (both outside the home and housework) quite a bit

Level 6: You have pain that interferes with your normal work (both outside the home and housework) extremely

**Mental Health:\***  Level 1: You feel tense or downhearted and low none of the time

Level 2: You feel tense or downhearted and low a little of the time

Level 3: You feel tense or downhearted and low some of the time

Level 4: You feel tense or downhearted and low most of the time

Level 5: You feel tense or downhearted and low all of the time

**Vitality:\***  Level 1: You have a lot of energy all of the time

Level 2: You have a lot of energy most of the time

Level 3: You have a lot of energy some of the time

Level 4: You have a lot of energy a little of the time

Level 5: You have a lot of energy none of the time

### Therapeutic Outcomes of the Procedure

**Was a Borg Score obtained within 30 days of the procedure (+ or – 2 weeks)?\***  Yes  
 Could not be obtained, patient was not capable  
 Was not obtained

*If yes* → Indicate your patients modified Borg score:  0-Nothing at all  0.5-Very, very slight  1-Very slight  
 2-Slight  3-Moderate  4-Somewhat severe  5- Severe  
 6  7-Very severe  8  9-Very, very severe  10-Maximal

---

**Were FEV1 and FVC obtained within 30 days of the procedure (+ or – 2 weeks)?\***  Yes  
 Could not be obtained, patient was not capable  
 Was not obtained

*If yes* → Indicate the patient’s FEV1 percent of predicted numeric value (range 1-200) \_\_\_\_\_  
*If yes* → Indicate the patient’s FVC percent of predicted numeric value (range 1-200) \_\_\_\_\_

**Comments**

**Use the space below to note any comments you feel are relevant to the procedure:**

---



---



---



---



---



---



---