OSCILLOMETRY DATA FORM

ID NUMBER: | | | | | | | | |

FORM CODE: **OSC**
VERSION: 1.0 06/19/2019

Event: ____________________

0a) Date of Collection ☐☐ / ☐☐ / ☐☐☐☐ 0b) Staff Code ☐☐☐

Instructions: *This form should be completed during the participant's clinic visit 5 or Bronchoscopy Substudy visit to document that the oscillometry testing occurred.*

1) Was pre-bronchodilator oscillometry testing done?

☐ No0 → **Go to Item 2**

☐ Yes1

1a) Time pre-bronchodilator testing began: ☐☐:☐☐ AM/PM

2) Was post-bronchodilator (after ipratropium and albuterol) oscillometry testing done?

☐ No0 → **Go to Item 3**

☐ Yes1

2a) Time first puff of bronchodilator given: ☐☐:☐☐ AM/PM

2b)Time slow vital capacity procedure began: ☐☐:☐☐ AM/PM

3) Were there any complications during any phase of oscillometry testing?

☐ No0→ **Go to Item 4**

☐ Yes1

3a) If Yes, please explain: ____

4) Other comments: ____

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END OF FORM