

COMPLETE IN BLUE OR BLACK INK

Claimant name					Claim number																			
Claimant Social Security number					Type of reading <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> P					Facility identification														
1a. Date of x-ray (mm/dd/yyyy)			1b. Film quality <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> U/R			If not grade L give reason					1c. Is film completely negative? <input type="checkbox"/> Yes (go to section 5) <input type="checkbox"/> No (go to section 2)													
2a. Any parenchymal abnormalities consistent with pneumoconiosis? <input type="checkbox"/> Yes (complete 2b and 2c) <input type="checkbox"/> No (proceed to section 3)																								
2b. Small opacities																								
a. Shape/size				b. Zones				c. Profusion			2c. Large opacities													
Primary		Secondary		R		L		0/1	0/0	0/1	O	A	B	C										
P	S	P	S																					
Q	T	Q	T					1/0	1/1	1/2														
R	U	R	U					2/1	2/2	2/3														
								3/2	3/3	3/4				Proceed to section 3a										
3a. Any pleural abnormalities consistent with pneumoconiosis? <input type="checkbox"/> Yes (complete 3b, 3c, 3d) <input type="checkbox"/> No (proceed to section 4a)																								
3b. Pleural thickening					3c. Pleural thickening....chest wall																			
a. Diaphragm (plaque)					a. Circumscribed (plaque)					b. Diffuse														
Site			O		R		L		Site in profile		O		R		O		L							
b. Costophrenic angle					i. Width					ii. Extent														
Site			O		R		L		O		A		B		C		O		1		2		3	
					Face on					Face on														
					iii. Extent					iii. Extent														
					O					O														
					1					1														
					2					2														
					3					3														
3d. Pleural calcification																								
Site			O		R		Extent			Site			O		R		Extent							
							0			0							0							
a. Diaphragm							1			1							1							
b. Wall							2			2							2							
c. Other sites							3			3							3							
4a. Any other abnormalities? <input type="checkbox"/> Yes (complete 4b and 4c) <input type="checkbox"/> No (proceed to section 5a)																								
O	AX	BU	CA	CN	CO	CP	CW	DI	EF	EM	ES	FR	HI	HO	ID	IH	KL	PI	PX	RP	TB			
Report items which may be of present clinical significance in this section.					OD					Date personal physician notified														
4c. Other comments																								
Should the worker see a personal physician because of comments in Section 4c? <input type="checkbox"/> Yes <input type="checkbox"/> No																								
5a. Film reader's initials					Physician FEIN					Date of reading														
Physician signature					Date																			