Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial

TRANSVAGINAL ULTRASOUND SCREENING EXAMINATION (TVU2)

1. Date of Examination: MO. DAY YR.

2. Satellite Center:

3. Study Year:
- ○ T_0
- ○ T_1
- ○ T_2
- ○ T_3

4. Visit Number:
- ○ One
- ○ Two
- ○ Three

5. Reason for Repeat Visit:

DO NOT FOLD, STAPLE, OR TEAR THIS FORM.
USE A NO. 2 PENCIL TO COMPLETE THIS FORM.

PART A: TRANSVAGINAL ULTRASOUND EXAMINATION FINDINGS

QUESTION	RIGHT	LEFT
1. Sonographically Detectable Ovary	○ No (GO TO 3) ○ Yes	○ No (GO TO 3) ○ Yes
2. Ovary Size (CALCULATE VOLUME: WIDTH X HEIGHT X THICKNESS X 0.523)	Longitudinal diameter (cm); Transverse diameter (cm); Antero-posterior diameter (cm); Volume (cc)	Longitudinal diameter (cm); Transverse diameter (cm); Antero-posterior diameter (cm); Volume (cc)
3. Number of Morphologic Abnormalities in Adnexal Area	○ None (GO TO LEFT) ○ One ○ Two ○ Three or more	○ None (GO TO 5) ○ One ○ Two ○ Three or more

4. Complete for Three Largest Discrete Cysts or Abnormalities :

	RIGHT #1	RIGHT #2	RIGHT #3	LEFT #1	LEFT #2	LEFT #3
A. Maximum Diameter of Cyst or Abnormality (in cm.)						

PLEASE DO NOT WRITE IN THIS AREA

157176

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QUESTION	RIGHT			LEFT		
	#1	#2	#3	#1	#2	#3
B. Volume of Cyst or Abnormality (in cc.) **CALCULATE VOLUME:** **[MAXIMUM DIAMETER]^3 x 0.523**						
C. Solid Area 0 = None 2 = All solid (GO TO 4G) 1 = Mixed	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
D. Septal Structure 0 = No septae 2 = Yes, thick (>3 mm) 1 = Yes, thin (≤3mm)	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
E. Cyst Outline 1 = Smooth 2 = Irregularities 3 = Papillarities	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
F. Cyst Wall Thickness 1 = Thin (≤3mm) 2 = Thick (>3mm)	1 2	1 2	1 2	1 2	1 2	1 2
G. Echogenicity 1 = Sonolucent 4 = Mixed 2 = Low 5 = High 3 = Low with echogenic core	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

5. Other Abnormalities Noted: ○ No ○ Yes (SPECIFY) _____

PART B: EXAMINATION RESULTS

1. Examination Result:
- ○ Positive Screen - Referral Required (GO TO 3)
- ○ Negative Screen - No Abnormalities (GO TO 3)
- ○ Negative Screen - Other Abnormalities (GO TO 3)
- ○ Inadequate

2. Reason for Inadequate Exam: (MARK ALL THAT APPLY)
- ○ Participant Discomfort
- ○ Participant Refusal
- ○ Equipment Malfunction
- ○ Inability to Insert Probe
- ○ Bowel Interference
- ○ Other (SPECIFY) _____

3. Level of Referral:
- ○ 1 - Significant Abnormality, Referral
- ○ 2 - Moderate Abnormality, Referral
- ○ 3 - Slight Variation from Normal, No Referral
- ○ 4 - Normal/Result Not Available, No Referral

4. Photo Documentation:
- ○ No
- ○ Yes

5. Medical Complications of Examination:
○ No ○ Yes (SPECIFY) _____

6. Comments:
○ No ○ Yes (SPECIFY)

Item #	Comments

○ Continued

7. Examiner ID: _____

Signature

8. Consultant ID: _____

○ No ○ Yes (SPECIFY) _____

Signature

For Office Use Only

Forms Processing (DARKEN CIRCLES AS STEPS ARE COMPLETED)

Data Retrieval:		Data Entry of Non-Scannable Items:		Final Disposition:	
Form Receipted into SMS ○	Attempted ○ OR None Required ○	Completed ○ OR None Required ○		Final Complete (FCM) ○ OR Final Incomplete (FIC) ○	
Manual Review Completed ○					