Subject No. ☐☐☐ - ☐☐☐ **Visit Date** ☐☐ ☐☐☐ ☐☐☐☐
Site *Subject* *day* *month* *year*

ECG

☐ Not Done

Result: ☐ Normal

☐ Abnormal, *specify:* _____

Was this result Clinically Significant?

☐ Yes

☐ No

CHEST X-RAY

☐ Not Done

Result: ☐ Normal

☐ Abnormal, *specify:* _____

Was this result Clinically Significant?

☐ Yes

☐ No

CT/MRI

☐ Not Done

Result: ☐ Normal

☐ Abnormal, *specify:* _____

Was this result Clinically Significant?

☐ Yes

☐ No