

FILE NUMBER:

PERSON'S NAME AND AGE:

FACILITY:

DANIEL POWERS, M.D.

B READER

AMERICAN BOARD OF RADIOLOGY CERTIFIED  
CALIFORNIA MEDICAL LICENSE # G 34426

DISCOVERY  
DIAGNOSTICS INC.

6200 WILSHIRE BLVD. #1008, LOS ANGELES, CA 90048  
(323) 933-5100 or (800) 222-6768

<b>1A. DATE OF CT</b> <table border="1" style="width:100%; text-align: center;"> <tr> <td style="width:33%;">MONTH</td> <td style="width:33%;">DAY</td> <td style="width:33%;">YEAR</td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table>	MONTH	DAY	YEAR				<b>1B. SCANNER</b> COMPANY, MODEL, SUPINE SPIRAL CT SCANNER 5 mm THICK SLICES, 5 mm APART	<b>1C. IS STUDY COMPLETELY NEGATIVE?</b> YES <input type="checkbox"/> Proceed to Medical/Legal Analysis    NO <input type="checkbox"/> Proceed to Section 2																																																																																					
MONTH	DAY	YEAR																																																																																											
<b>2A. ANY PARENCHYMAL ABNORMALITIES CONSISTENT WITH PNEUMOCONIOSIS?</b> YES <input type="checkbox"/> COMPLETE 2B and 2C    NO <input type="checkbox"/> PROCEED TO SECTION 3																																																																																													
<b>2B. SMALL OPACITIES</b> a. NO VISUALIZED INTERSTITIAL CHANGES—SUGGEST PRONE HRCT TO EXCLUDE MILD DISEASE <input type="checkbox"/> b. DEPENDENT DENSITY MAKING MILD DISEASE DIFFICULT TO IDENTIFY—SUGGEST PRONE HRCT <input type="checkbox"/> c. MODERATE DISEASE <input type="checkbox"/> d. SEVERE DISEASE <input type="checkbox"/>	<b>2C. NODULES/MASSES</b> SITE NON-CALCIFIED NODULES UNDER 5mm: ..... <table border="1" style="display: inline-table; text-align: center;"><tr><td>O</td><td>R</td><td>L</td></tr></table> NON-CALCIFIED NODULES ≥ 5mm: ..... <table border="1" style="display: inline-table; text-align: center;"><tr><td>O</td><td>R</td><td>L</td></tr></table> PROBABLE CALCIFIED GRANULOMA(S) ..... <table border="1" style="display: inline-table; text-align: center;"><tr><td>O</td><td>R</td><td>L</td></tr></table> ROUNDED ATELECTASIS ..... <table border="1" style="display: inline-table; text-align: center;"><tr><td>O</td><td>R</td><td>L</td></tr></table> CICATRIAL MASS ..... <table border="1" style="display: inline-table; text-align: center;"><tr><td>O</td><td>R</td><td>L</td></tr></table> PROCEED TO SECTION 3		O	R	L	O	R	L	O	R	L	O	R	L	O	R	L																																																																												
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<b>3A. ANY PLEURAL ABNORMALITIES CONSISTENT WITH PNEUMOCONIOSIS?</b> YES <input type="checkbox"/> COMPLETE 3B, 3C, and 3D    NO <input type="checkbox"/> PROCEED TO SECTION 4																																																																																													
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<b>4A. ANY OTHER ABNORMALITIES?</b> YES <input type="checkbox"/> COMPLETE 4B, 4C, 4D, 4E    NO <input type="checkbox"/>																																																																																													
<b>4B. OTHER SYMBOLS (OBLIGATORY)</b> <table style="width:100%; text-align: center;"> <tr> <td><input type="checkbox"/> O</td><td><input type="checkbox"/> aa</td><td><input type="checkbox"/> at</td><td><input type="checkbox"/> ax</td><td><input type="checkbox"/> bu</td><td><input type="checkbox"/> ca</td><td><input type="checkbox"/> cg</td><td><input type="checkbox"/> cn</td><td><input type="checkbox"/> co</td><td><input type="checkbox"/> cp</td><td><input type="checkbox"/> cv</td><td><input type="checkbox"/> di</td><td><input type="checkbox"/> ef</td><td><input type="checkbox"/> em</td><td><input type="checkbox"/> es</td><td><input type="checkbox"/> fr</td><td><input type="checkbox"/> hi</td><td><input type="checkbox"/> ho</td><td><input type="checkbox"/> id</td><td><input type="checkbox"/> ih</td><td><input type="checkbox"/> kl</td><td><input type="checkbox"/> me</td><td><input type="checkbox"/> pa</td><td><input type="checkbox"/> pb</td><td><input type="checkbox"/> pi</td><td><input type="checkbox"/> px</td><td><input type="checkbox"/> ra</td><td><input type="checkbox"/> rp</td><td><input type="checkbox"/> tb</td> </tr> </table> Other diseases or significant abnormalities: <input type="checkbox"/> OD _____ Date Personal Physician or Worker Notified? <table border="1" style="display: inline-table; text-align: center;"><tr><td>MONTH</td><td>DAY</td><td>YEAR</td></tr><tr><td> </td><td> </td><td> </td></tr></table>			<input type="checkbox"/> O	<input type="checkbox"/> aa	<input type="checkbox"/> at	<input type="checkbox"/> ax	<input type="checkbox"/> bu	<input type="checkbox"/> ca	<input type="checkbox"/> cg	<input type="checkbox"/> cn	<input type="checkbox"/> co	<input type="checkbox"/> cp	<input type="checkbox"/> cv	<input type="checkbox"/> di	<input type="checkbox"/> ef	<input type="checkbox"/> em	<input type="checkbox"/> es	<input type="checkbox"/> fr	<input type="checkbox"/> hi	<input type="checkbox"/> ho	<input type="checkbox"/> id	<input type="checkbox"/> ih	<input type="checkbox"/> kl	<input type="checkbox"/> me	<input type="checkbox"/> pa	<input type="checkbox"/> pb	<input type="checkbox"/> pi	<input type="checkbox"/> px	<input type="checkbox"/> ra	<input type="checkbox"/> rp	<input type="checkbox"/> tb	MONTH	DAY	YEAR																																																											
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<b>4C/D. OTHER COMMENTS?</b> _____ _____ _____ _____																																																																																													
<b>4E. SHOULD PERSON SEE PERSONAL PHYSICIAN BECAUSE OF FINDINGS IN SECTIONS 4B, 4C, 4D?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (UNLESS CLINICALLY INDICATED)																																																																																													

- NO CT EVIDENCE FOR ASBESTOSIS AT THIS TIME.
- PLEURAL PLAQUE FORMATION CONSISTENT WITH PRIOR ASBESTOS EXPOSURE.
- PARENCHYMAL CHANGES HAVING THE APPEARANCE AND DISTRIBUTION OF ASBESTOSIS.
- PARENCHYMAL CHANGES AND PLEURAL PLAQUING CONSISTENT WITH THE CT DIAGNOSIS OF ASBESTOSIS.