4179037067

ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY)
FORM 18N - 12 MONTH FOLLOW-UP FOR NON-VA PATIENTS

Hospital No. | Patient ID | Patient Initials | Date Form Completed (mm/dd/yy)

1. Has the patient died? ☐ Yes ☐ No

If Yes,
a. Date of Death ___/___/___ (mm/dd/yy)

I am going to read you a list of questions about medical care since _____ (60-Day survey date), the date of the last survey. When I say the study hospital, I mean the hospital where you were treated for kidney failure about 12 months ago.

2. Since _____ (60-day survey date), were [you/patient] admitted to any hospital other than the study hospital? ☐ Yes ☐ No

If Yes,
a. Admission date: ___/___/___ (mm/dd/yy)

b. Facility name:

c. City and state where facility located:

d. How many days did [you/patient] stay in the hospital? ___ days

e. How many days were [you/patient] in the Intensive Care Unit? ___ days

f. Have there been additional hospital admissions? ☐ Yes ☐ No

If Yes, use the continuation sheets on pages 4 and 5 to record hospital admissions.

Hospital No. | Patient ID | Patient Initials

3. Since _____, were [you/patient] admitted to any nursing home? ☐ Yes ☐ No
(60-day survey date)

If Yes,

a. Admission date: ---------- / / (mm/dd/yy)

b. Facility name:

c. City and state where facility located:

d. How many days were [you/patient] in the nursing home? days

e. Have there been additional nursing home admissions? ---------- ☐ Yes ☐ No

If Yes, use the continuation sheets on pages 4 and 5 to record additional visits.

4. Since _____, were [you/patient] admitted to any hospice? ---------- ☐ Yes ☐ No
(60 day survey date)

If Yes,

a. Admission date: ---------- / / (mm/dd/yy)

b. Facility name:

c. City and state where facility located:

d. How many days were [you/patient] in the hospice? days

e. Have there been additional hospice admissions? ---------- ☐ Yes ☐ No

If Yes, use continuation sheets on pages 4 and 5 to record additional hospice admissions.

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Hospital No. ☐☐☐ Patient ID ☐☐☐ Patient Initials ☐☐☐

Now I'd like to ask about outpatient care, such as doctor appointments and visits to kidney dialysis clinics.

5. Since _____, have [you/patient] had any medical appointments outside the study
(60-day survey date)
hospital concerning kidney problems? ---------- Yes ☐ No ☐

If Yes,

a. How many medical appointments? ---------- ☐☐

b How many miles each way did [you/patient] travel on average? ☐☐☐ miles

c. Did someone go with [you/patient] most times? ☐ yes ☐ no

6 Since _____, have [you/patient] received regular kidney dialysis
(60-day survey date)
treatments outside the study hospital? ---------- Yes ☐ No ☐

If Yes,

a. How many times per week? ---------- ☐

b How many miles each way did [you/patient] travel for treatment? ☐☐☐ miles

c. Did someone go with [you/patient] most times? ☐ yes ☐ no

7. Since _____, have [you/patient] had any medical appointment outside
(60-day survey date)
the hospital for something other than kidney problems? ---------- Yes ☐ No ☐

If Yes,

a. How many times? ---------- ☐☐

b. How many miles each way did [you/patient] travel, on average. ☐☐☐ miles

c. Did someone go with [you/patient] most times? ------- ☐ yes ☐ no

8. In the last week, has someone helped [you/patient] around the house with healthcare, such as changing bandages or giving medications? ---------- Yes ☐ No ☐

If Yes,

a. How many hours did someone help with healthcare last week? --------- ☐☐☐ hours

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USE THIS PAGE TO RECORD ADDITIONAL ADMISSIONS TO HOSPITALS, NURSING HOMES, OR HOSPICE.

9. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __ (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an intensive care unit? __ days

10. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __ (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an intensive care unit? __ days

11. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an intensive care unit? __ days

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12. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __ (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an intensive care unit? __ days

13. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __ (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an intensive care unit? __ days

14. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __ (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an intensive care unit? __ days

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FOR STUDY COORDINATOR USE ONLY

1. Who answered the questions on this form (check one)?

☐ Study Subject

☐ Someone who lives with the subject

☐ Someone who does not live with the subject

☐ No-one

2. Were all questions answered? ---------- ☐ Yes ☐ No

If No, please give reason:

3. If the questionnaire was not completed, indicate the main reason (check one)

☐ Subject deceased and no-one else was available

☐ Subject could not be contacted

☐ Subject refused to complete

☐ Subject could not complete due to illness or other reason and no-one else was available

☐ Questionnaire not administered due to institution error

☐ Other, specify

That's the end of the survey. Thank you.

Staff Initials