

ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY)

FORM 04 - BASELINE FORM

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Hospital			PatID			PatInits			Date	
									Date Form Completed (mm/dd/yy)	

COMPLETE THIS FORM BETWEEN RANDOMIZATION AND FIRST STUDY TREATMENT

A. Primary Diagnosis at Time of Onset of ARF

PrimDx1[illegible][illegible]

2. Is patient post "open" surgical procedure?----- Yes ☐ No ☐ PostSurgicalProc

B. Primary treating service (check one)

PrimaryTreat

	PrimTreatDesc
0	No treatment
1	Treatment A
2	Treatment B
3	Treatment C
4	Treatment D
5	Treatment E
6	Treatment F
7	Treatment G
8	Treatment H
9	Treatment I
10	Treatment J
11	Treatment K
12	Treatment L
13	Treatment M
14	Treatment N
15	Treatment O
16	Treatment P
17	Treatment Q
18	Treatment R
19	Treatment S
20	Treatment T
21	Treatment U
22	Treatment V
23	Treatment W
24	Treatment X
25	Treatment Y
26	Treatment Z
27	Treatment AA
28	Treatment AB
29	Treatment AC
30	Treatment AD
31	Treatment AE
32	Treatment AF
33	Treatment AG
34	Treatment AH
35	Treatment AI
36	Treatment AJ
37	Treatment AK
38	Treatment AL
39	Treatment AM
40	Treatment AN
41	Treatment AO
42	Treatment AP
43	Treatment AQ
44	Treatment AR
45	Treatment AS
46	Treatment AT
47	Treatment AU
48	Treatment AV
49	Treatment AW
50	Treatment AX
51	Treatment AY
52	Treatment AZ
53	Treatment BA
54	Treatment BB
55	Treatment BC
56	Treatment BD
57	Treatment BE
58	Treatment BF
59	Treatment BG
60	Treatment BH
61	Treatment BI
62	Treatment BJ
63	Treatment BK
64	Treatment BL
65	Treatment BM
66	Treatment BN
67	Treatment BO
68	Treatment BP
69	Treatment BQ
70	Treatment BR
71	Treatment BS
72	Treatment BT
73	Treatment BU
74	Treatment BV
75	Treatment BW
76	Treatment BX
77	Treatment BY
78	Treatment BZ
79	Treatment CA
80	Treatment CB
81	Treatment CC
82	Treatment CD
83	Treatment CE
84	Treatment CF
85	Treatment CG
86	Treatment CH
87	Treatment CI
88	Treatment CJ
89	Treatment CK
90	Treatment CL
91	Treatment CM
92	Treatment CN
93	Treatment CO
94	Treatment CP
95	Treatment CQ
96	Treatment CR
97	Treatment CS
98	Treatment CT
99	Treatment CU
100	Treatment CV
101	Treatment CW
102	Treatment CX
103	Treatment CY
104	Treatment CZ
105	Treatment DA
106	Treatment DB
107	Treatment DC
108	Treatment DD
109	Treatment DE
110	Treatment DF
111	Treatment DG
112	Treatment DH
113	Treatment DI
114	Treatment DJ
115	Treatment DK
116	Treatment DL
117	Treatment DM
118	Treatment DN
119	Treatment DO
120	Treatment DP
121	Treatment DQ
122	Treatment DR
123	Treatment DS
124	Treatment DT
125	Treatment DU
126	Treatment DV
127	Treatment DW
128	Treatment DX
129	Treatment DY
130	Treatment DZ
131	Treatment EA
132	Treatment EB
133	Treatment EC
134	Treatment ED
135	Treatment EE
136	Treatment EF
137	Treatment EG
138	Treatment EH
139	Treatment EI
140	Treatment EJ
141	Treatment EK
142	Treatment EL
143	Treatment EM
144	Treatment EN
145	Treatment EO
146	Treatment EP
147	Treatment EQ
148	Treatment ER
149	Treatment ES
150	Treatment ET
151	Treatment EU
152	Treatment EV
153	Treatment EW
154	Treatment EX
155	Treatment EY
156	Treatment EZ
157	Treatment FA
158	Treatment FB
159	Treatment FC
160	Treatment FD
161	Treatment FE
162	Treatment FF
163	Treatment FG
164	Treatment FH
165	Treatment FI
166	Treatment FJ
167	Treatment FK
168	Treatment FL
169	Treatment FM
170	Treatment FN
171	Treatment FO
172	Treatment FP
173	Treatment FQ
174	Treatment FR
175	Treatment FS
176	Treatment FT
177	Treatment FU
178	Treatment FV
179	Treatment FW
180	Treatment FX
181	Treatment FY
182	Treatment FZ
183	Treatment GA
184	Treatment GB
185	Treatment GC
186	Treatment GD
187	Treatment GE
188	Treatment GF
189	Treatment GG
190	Treatment GH
191	Treatment GI
192	Treatment GJ
193	Treatment GK
194	Treatment GL
195	Treatment GM
196	Treatment GN
197	Treatment GO

☐ Medical ☐ Surgical ☐ Other, specify _____

[illegible]

C. ARF Information

1. Etiology of Acute Renal Failure:

a. Ischemic-----Ischemic-----Yes ☐ No ☐

b. Nephrotoxic _____ Yes ☐ No ☐

c. Sepsis Sepsis Yes ☐ No ☐

d. Multifactorial-----Sepsis Yes ☐ No ☐

NephrotoxicMultifactorial

D. Hospitalization History

1. Date of Current Hospital Admission	CurrAdmitDate	/	/	mm/dd/yy
---------------------------------------	---------------	---	---	----------

2. Date of ICU Admission _____ ICUAdmitDate _____ / _____ / _____ mm/dd/yy

3. Was patient transferred from an outside hospital?-----Transfer Yes ☐ No ☐

4. Patient was admitted from: (choose one)

[□ Home](#)

AdmitFrom☐ Skilled Nursing Facility☐ Assisted Living FacilityAdmitDesc☐ Other (specify) _____[illegible]

E. Demographic Information

1. Date of birth-----

DOB

-----/-----/-----(mm/dd/yy)

2. Age (years) ----- Age years

3. Gender..... Gender ☐ Male ☐ Female

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4. Racial/Ethnic Origin (check one)

Race

- | | |
|--------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> White, not of Hispanic Origin | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Black, not of Hispanic Origin | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian | |

F. Military Service History

MilitaryServ

1. Has the patient ever served in the U.S. military? ----- Yes
- ☐
- No
- ☐
- N/A*
- ☐

If yes, complete rest of Section F

If no or N/A, skip to Section G

Activeduty

2. Active duty ----- Yes
- ☐
- No
- ☐
- N/A*
- ☐

3. Reserves only ----- Reserves Yes
- ☐
- No
- ☐
- N/A*
- ☐

4. When did the patient serve (check all that apply)

- | | | | |
|----------------------------------|-------------------------------------------|----------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> WWI | <input type="checkbox"/> World War I | <input type="checkbox"/> Afghanistan Conflict | <input type="checkbox"/> Afghan |
| <input type="checkbox"/> WWII | <input type="checkbox"/> World War II | <input type="checkbox"/> Gulf War | <input type="checkbox"/> Gulf |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Korean Conflict | <input type="checkbox"/> Peace Time | <input type="checkbox"/> Peace |
| <input type="checkbox"/> Vietnam | <input type="checkbox"/> Vietnam Conflict | <input type="checkbox"/> Information not available | <input type="checkbox"/> InfoNA |
| <input type="checkbox"/> Balkans | <input type="checkbox"/> Balkans Conflict | <input type="checkbox"/> Other | <input type="checkbox"/> Other War/Conflict (specify) |

WarConflictDesc

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5. Did the patient serve outside the United States? ----- OutsideUS Yes
- ☐
- No
- ☐
- N/A*
- ☐

6. What was the branch of service (check all that apply)

- | | | | | | |
|-------------------------------|------------------------------------|-----------------------------------------|--------------------------------------|----------------------------------------------------|----------------------------------|
| <input type="checkbox"/> Army | <input type="checkbox"/> Army | <input type="checkbox"/> Marines | <input type="checkbox"/> Marines | <input type="checkbox"/> Information not available | <input type="checkbox"/> InforNA |
| <input type="checkbox"/> Air | <input type="checkbox"/> Air Force | <input type="checkbox"/> Coast | <input type="checkbox"/> Coast Guard | | |
| <input type="checkbox"/> Navy | <input type="checkbox"/> Navy | <input type="checkbox"/> National Guard | <input type="checkbox"/> NatGuard | | |

G. Medical History

1. Cardiovascular disease

- | | | | | |
|-------------------------------------|----------------|--------------------------|--------------------------|--------------------------|
| a. Documented myocardial infarction | MI | Yes | No | N/A* |
| b. Angina | Angina | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Symptoms at rest | AnginaSymptoms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Congestive Heart Failure | CHF | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Symptoms at rest | CHFSymptoms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*N/A means Information Not Available

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	Yes	No	N/A*	
2. Peripheral Vascular Disease (includes untreated aortic aneurysm \geq 6cm) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PVD
3. Cerebrovascular Disease				
a. TIA's -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TIA
b. CVA with minor or no residual defect -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CVAMinor
c. CVA with residual hemiplegia -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CVAMajor
4. Dementia (includes cognitive deficits) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dementia
5. Chronic Pulmonary Disease				
a. Chronic hypoxemia -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ChronHypoxemia
b. Hypercapnia -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypercapnia
c. Secondary polycythemia -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ploicythmia
d. Severe pulmonary hypertension -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
e. Chronic ventilator dependence -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CVD
6. Connective Tissue Disorder -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CTD
7. Peptic Ulcer Disease (with or without bleeding) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
8. Chronic liver disease				
a. Mild liver disease - chronic hepatitis or cirrhosis without portal HTN -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MildLiverDisease
b. Moderate or severe liver disease (cirrhosis with portal HTN, with or without variceal bleeding) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LiverDisease
c. Encephalopathy -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Encephalopathy
9. Diabetes Mellitus				
a. Treated with diet alone -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DMDiet
b. Treated with oral hypoglycemic agents or insulin -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DMMeds
c. With end-organ disease (retinopathy or neuropathy) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DMEndOrganDis
10. Malignancy				
a. Solid tumor without metastases -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MaligNoMetast
b. Solid tumor with metastases -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MaligMetast
c. Leukemia or lymphoma -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemic
11. Immune-suppressed				
a. HIV+ (not AIDS) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV
b. AIDS (not just HIV+) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS
c. On immunosuppression -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ImmunoTherapy
d. Other immune compromised state -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ImmuneCompromise

*N/A means Information Not Available

Hospital

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H. Physical Exam

1. Pre-morbid Body Weight -----

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 kg **Weight**2. Pre-morbid Height -----

--	--

 inches **Height**3. Ideal Body Weight -----

--	--	--

 .

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 kg **IdealWeight**a. If actual pre-morbid body weight is >30% above ideal body weight, enter
adjusted pre-morbid weight (see Ops Manual)

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 .

--

 kg **AdjustedWeight**

4. Blood Pressure

SystolicSystolic BP

--	--	--

 mmHgDiastolic BP

--	--	--

 mmHg **Diastolic**

I. Nutrition Management

NPO1. NPO ----- Yes ☐ No ☐2. Oral Supplements ----- **OralSupp** Yes ☐ No ☐a. Type of Supplement (see Ops Manual for codes) -----

--	--	--

TypeSuppb. Number of mL administered per day ----- **OralSupp mL**

--	--	--	--

 mL3. Tube Feed ----- **TubeFeed** Yes ☐ No ☐a. Formulation (see Ops Manual for codes) ----- **Formulation**

--	--	--

b. Number of mL administered per day ----- **TubeFeed mL**

--	--	--	--

 mL4. TPN ----- Yes ☐ No ☐ **TPN**a. Calories/day ----- **Calories**

--	--	--	--

b. Protein/day ----- **Protein**

--	--	--

 gramsc. Lipids/day ----- **Lipids**

--	--	--

 grams

NOTE: Complete the Patient Contact Information Form (Form 05), Baseline Scores and
Labs Form (Form 06) and Release of Information Form (Form 14) for this patient.

StaffInits

Staff Initials

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