Annotated form 2385439262

VA WEST HAVEN CSP530A

ACUTE RENAL FAILURE TRIAL NETWORK (OBSERVATIONAL STUDY)

FORM 22 - ENTRY FORM

Hospital ☐☐☐ PatID ☐☐☐

Date Form Completed (mm/dd/yy) ☐☐ / ☐☐ / ☐☐ Date

A. Demographic Information

1. Age ☐☐☐ years Age

2. Gender: ☐ male ☐ female Gender

3. Racial/Ethnic Origin:

☐ White, not of Hispanic Origin
☐ Black, not of Hispanic Origin
☐ Hispanic
☐ Asian
☐ Pacific Islander
☐ American Indian/Alaskan Native
☐ Other

Race

4. Etiology of Acute Tubular Necrosis (choose one):

☐ Ischemic
☐ Nephrotoxic
☐ Sepsis
☐ Multifactorial

EtiologyATN

ReceiveRRT

B. Did patient receive Renal Replacement Therapy within 14 day of Screening? -------- ☐ Yes ☐ No

1. If no, please skip to the end of this form, enter staff initials, and send form to WH CSPCC.
2. If yes, complete the remainder of the form and send form to WH CSPCC with the patient's RRT forms (Observational Study Forms 23).

C. Renal Replacement Therapy (RRT) Data

DayPostScreen

1. Day post-screening that RRT was started (day 01=screening day). ☐☐

2. Indication for RRT (choose all that apply).

☐ Volume overload Volume
☐ Persistent hyperkalemia Persistent
☐ Severe metabolic acidosis Severe
☐ Azotemia Azotemia

3. BUN on date RRT initiated: ☐☐☐ mg/dL BUN

4. SOFA Cardiovascular Score at time of initiation of RRT: ☐ CardioSofaScore

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5. For days 1 through 14 post-screening, indicate whether RRT was provided and if provided, what modality was used. For each day when RRT was provided, check all modalities that apply. Day 1 is day of screening.

Day 1:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT1	IHD1	SLED1	CRRT1
Day 2:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT2	IHD2	SLED2	CRRT2
Day 3:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT3	IHD3	SLED3	CRRT3
Day 4:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT4	IHD4	SLED4	CRRT4
Day 5:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT5	IHD5	SLED5	CRRT5
Day 6:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT6	IHD6	SLED6	CRRT6
Day 7:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT7	IHD7	SLED7	CRRT7
Day 8:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT8	IHD8	SLED8	CRRT8
Day 9:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT9	IHD9	SLED9	CRRT9
Day 10:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT10	IHD10	SLED10	CRRT10
Day 11:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT11	IHD11	SLED11	CRRT11
Day 12:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT12	IHD12	SLED12	CRRT12
Day 13:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT13	IHD13	SLED13	CRRT13
Day 14:	☐ No RRT	☐ IHD	☐ SLED	☐ CRRT	NoRRT14	IHD14	SLED14	CRRT14

6. Complete a Form 23 for each treatment provided on each of the 14 days post screening.

NOTE: Mail Form 22 and all Forms 23 for this patient to WH CSPCC together at the end of the 14 day post-screening period.

Staff Initials

StaffInits ☐☐☐