ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY)
FORM 04 - BASELINE FORM

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

COMPLETE THIS FORM BETWEEN RANDOMIZATION AND FIRST STUDY TREATMENT

A. Primary Diagnosis at Time of Onset of ARF

1. Diagnosis

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

B. Primary treating service (check one)

☐ Medical ☐ Surgical ☐ Other, specify

C. ARF Information

1. Etiology of Acute Renal Failure:
   a. Ischemic ☐ Yes ☐ No
   b. Nephrotoxic ☐ Yes ☐ No
   c. Sepsis ☐ Yes ☐ No
   d. Multifactorial ☐ Yes ☐ No

D. Hospitalization History

1. Date of Current Hospital Admission / / mm/dd/yy
2. Date of ICU Admission / / mm/dd/yy
3. Was patient transferred from an outside hospital? ☐ Yes ☐ No
4. Patient was admitted from: (choose one)
   ☐ Home
   ☐ Skilled Nursing Facility
   ☐ Assisted Living Facility
   ☐ Other (specify)

E. Demographic Information

1. Date of birth / / (mm/dd/yy)
2. Age (years) years
3. Gender ☐ Male ☐ Female

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4. Racial/Ethnic Origin (check one)

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

F. Military Service History

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

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

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

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

- ☐ World War I
- ☐ World War II
- ☐ Korean Conflict
- ☐ Vietnam Conflict
- ☐ Balkans Conflict
- ☐ Afghanistan Conflict
- ☐ Gulf War
- ☐ Peace Time
- ☐ Information not available
- ☐ Other War/Conflict (specify)

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

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

- ☐ Army
- ☐ Air Force
- ☐ Navy
- ☐ Marines
- ☐ Coast Guard
- ☐ National Guard
- ☐ Information not available

G. Medical History

	Yes	No	N/A*
1. Cardiovascular disease			
a. Documented myocardial infarction	☐	☐	☐
b. Angina	☐	☐	☐
i. Symptoms at rest	☐	☐	☐
c. Congestive Heart Failure	☐	☐	☐
i. Symptoms at rest	☐	☐	☐

*N/A means Information Not Available

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

*N/A means Information Not Available

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H. Physical Exam

1. Pre-morbid Body Weight ☐☐☐.☐ kg
2. Pre-morbid Height ☐☐ inches
3. Ideal Body Weight ☐☐☐.☐ kg
   a. If actual pre-morbid body weight is >30% above ideal body weight, enter adjusted pre-morbid weight (see Ops Manual) ☐☐☐.☐ kg
4. Blood Pressure
   Systolic BP ☐☐☐ mmHg Diastolic BP ☐☐☐ mmHg

I. Nutrition Management

1. NPO Yes ☐ No ☐
2. Oral Supplements Yes ☐ No ☐
   a. Type of Supplement (see Ops Manual for codes) ☐☐☐
   b. Number of mL administered per day ☐☐☐☐ mL
3. Tube Feed Yes ☐ No ☐
   a. Formulation (see Ops Manual for codes) ☐☐☐
   b. Number of mL administered per day ☐☐☐☐ mL
4. TPN Yes ☐ No ☐
   a. Calories/day ☐☐☐☐
   b. Protein/day ☐☐☐ grams
   c. Lipids/day ☐☐☐ 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.

Staff Initials ☐☐☐