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ACUTE RENAL FAILURE TRIAL NETWORK (OBSERVATIONAL STUDY)

FORM 23 - RENAL REPLACEMENT THERAPY - EACH TREATMENT

Hospital No. | Patient ID | Treatment Day Code 01,02,...,14 | Treatment No. This Day | Date Form Completed (mm/dd/yy)

A. Time of day RRT started (military) ____ hours

1. If on continuous therapy, is it continued from previous day? ☐ Yes ☐ No

B. Selection of RRT Modality

1. Cardiovascular SOFA Score ____

2. Type of RRT (check one)

☐ Hemodialysis (complete section D) ☐ CRRT (complete section E)

☐ SLED (complete section D) ☐ Isolated Ultrafiltration (complete section C)

C. ISOLATED ULTRAFILTRATION

1. Indication for isolated ultrafiltration

a. Severe Edema ☐ Yes ☐ No

b. Lungs (check one) ☐ Clear ☐ Pulmonary Vascular Congestion

c. CVP ____ mmHg ☐ N/A*

d. Pulmonary Artery Pressure (systolic/diastolic) ____ / ____ mmHg ☐ N/A*

e. Pulmonary Capillary Occlusion Pressure ____ mmHg ☐ N/A*

f. Oxygenation SaO_2 ____ % **OR** PaO_2 ____ mmHg

FiO_2 ____ % **OR** Oxygen flow rate ____ liters/min

2. Duration of ultrafiltration ____ hours ____ minutes

3. Dialyzer (see Ops manual for codes) ____

4. Blood flow rate ____ mL/min

5. Pre-treatment weight ____ . ____ kg ☐ N/A*

6. Fluid removal ____ . ____ L

*N/A means Not Available

Clear Form

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D. HEMODIALYSIS or SLED

1. Dialyzer (see Ops Manual for codes) ____

2. Actual duration of dialysis (hours and minutes) ____ hours ____ mins

3. Blood flow rate (average achieved) ____ mL/min

4. Dialysate flow rate ____ mL/min

5. Pre-dialysis weight ____.____ kg ☐ N/A*

6. Net fluid removal (based on ultrafiltration monitor and administered fluids) ____.____ L

7. Assessment of dialysis adequacy performed? Yes ☐ No ☐

If yes, a. BUN at initiation of today's treatment ____ mg/dL

b. BUN at termination of today's treatment ____ mg/dL

c. Calculated spKt/V ____.____

8. Anticoagulation (choose one)

☐ None ☐ Heparin ☐ Citrate ☐ Other, specify ____

9. Clotting of extracorporeal circuit requiring hemodialyzer replacement? ☐ Yes ☐ No

10. a. Blood pressure at initiation of treatment ____ / ____ mmHg

b. Lowest documented blood pressure during treatment ____ / ____ mmHg

E. CRRT

1. Hemodiafilter (see Ops Manual for codes) ____

2. Actual duration of therapy (hours and minutes) ____ hours ____ mins

3. Blood flow rate (prescribed) ____ mL/min

4. Dialysate flow rate (prescribed) a. ____ mL/hour

b. Dialysate code ____ (see Ops Manual)

5. Replacement fluid administration rate (prescribed) a. ____ mL/hour

b. Replacement Fluid Code ____ (see Ops Manual)

*N/A means Not Available

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E. CRRT (cont'd)

6. Ultrafiltration rate (prescribed) ---------- ☐☐☐☐ mL/hour

7. 24-hour effluent volume (actual) ---------- ☐☐☐.☐ L

8. Anticoagulation (choose one)

☐ None ☐ Heparin ☐ Citrate ☐ Other, specify ☐

9. Clotting of extracorporeal circuit requiring hemodiafilter replacement? ---------- ☐ Yes ☐ No

10. Number of hemodiafilters used during this 24-hour treatment period ---------- ☐☐

F. COMPLICATIONS OF THERAPY (complete for all types of RRT)

	No	Yes
1. Anaphylactic reaction to dialyzer ("first-use" reaction) ----------	☐	☐
2. Hypotension requiring initiation of pressor support during treatment ----------	☐	☐
3. Hypotension requiring discontinuation of therapy ----------	☐	☐
4. Hypotension requiring other intervention ----------	☐	☐
5. Air embolism ----------	☐	☐
6. Bleeding (e.g., due to system disconnection or dialyzer rupture) ----------	☐	☐
7. New onset of serious arrythmia requiring discontinuation of therapy (e.g., rapid supraventricular tachycardia with hypotension, ventricular tachycardia) ----------	☐	☐
8. Iatrogenic fluid and/or electrolyte imbalances ----------	☐	☐
a. If yes, type of imbalance (see OPs Manual) ☐☐		
9. Seizures ----------	☐	☐
10. Other ----------	☐	☐

Specify:

Staff Initials ☐☐☐