ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY)
FORM 09 - RENAL REPLACEMENT THERAPY - EACH TREATMENT

Hospital No. | Patient ID | Patient Initials | Treatment Date (mm/dd/yy) | Treatment No. This Date

A. Treatment Day (choose one only)

1. ☐☐ Pre-randomization (code 00) 2. ☐☐ Study Day (code 01, 02, 03,...,28)

B. Time of day RRT started (military) ☐☐☐☐ hours

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

C. Selection of RRT Modality

1. Cardiovascular SOFA Score ☐

2. Type of RRT (check one)

☐ Hemodialysis (complete section E) ☐ CVVHDF (complete section F)

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

D. 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) ☐☐ mL/min
4. Blood flow rate ☐☐☐
5. Pre-treatment weight ☐☐☐.☐ kg ☐ N/A*
6. Fluid removal ☐☐.☐ L

*N/A means Not Available

Clear Form

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E. 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 ☐

NOTE: Pre-and Post-dialysis BUNs are to be collected and Kt/V calculated at least 3 times per week for first 2 weeks on study and at least once per week for the remainder of the time the patient is on the study therapy.

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

F. CVVHDF

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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F. CVVHDF (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 ----------

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

	No	Yes	If Yes, check if it is an SAE*
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:

NOTE: *IF ANY COMPLICATIONS HAVE OCCURRED THAT ARE BOTH SERIOUS AND TREATMENT-RELATED, PLEASE FILL OUT A SEPARATE SERIOUS ADVERSE EVENT FORM (Form 16) FOR EACH.

Date of Form Completion (mm/dd/yy) | Staff Initials