ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY)
FORM 18V - 12 MONTH FOLLOW-UP FOR VA PATIENTS

Hospital No. ☐☐☐ Patient ID ☐☐☐ Patient Initials ☐☐☐ Date Form Completed ☐☐/☐☐/☐☐

1. Has the patient died? Yes ☐ No ☐

If Yes,

a. Date of Death ☐☐/☐☐/☐☐ (mm/dd/yy)

I am going to read you a list of questions about medical care that [you/patient] may have received outside of the VA system. I am only interested in care you received since _____ , the date of the last survey.
(60-Day survey date)

2. Since _____, were [you/patient] admitted to any hospital outside the VA System? Yes ☐ No ☐
(60-day survey date)

If Yes,

a. Admission date: ☐☐/☐☐/☐☐ (mm/dd/yy)

b. Facility name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. City and state where facility located: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐

d. How many days did [you/patient] stay in that hospital? ☐☐☐ Days

e. How many days were [you/patient] in the Intensive Care Unit? ☐☐☐ Days

f. Have there been additional admissions? ☐ yes ☐ no

If Yes, use the continuation sheets on pages 4 and 5 to record additional hospital admissions.

3. Since _____, were [you/patient] admitted to any nursing home outside the VA System? Yes ☐ No ☐
(60-day survey date)

If Yes,

a. Admission date: ☐☐/☐☐/☐☐ (mm/dd/yy)

b. Facility name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. City and state where facility located: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐

d. How many days were [you/patient] in the nursing home? ☐☐☐ Days

e. Have there been additional nursing home admissions? ☐ yes ☐ no

If Yes, use the continuation sheets on pages 4 and 5 to record additional nursing home admissions.

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4. Since _____, were [you/patient] admitted to any hospice outside the VA System? Yes ☐ No ☐
(60- day survey date)

If Yes,

a. Admission date: ---------- / / (mm/dd/yy)

b. Facility name:

c. City and state where facility located:

d. How many days were [you/patient] in the hospice? ---------- Days

e. Has there been additional hospice admissions? ☐ yes ☐ no

If Yes, use the continuation sheets on pages 4 and 5 to record additional hospice admissions.

Now I'd like to ask about outpatient care, such as doctor appointments and visits to dialysis clinics. I'm only interested in outpatient visits outside the VA system.

5. Since _____, have [you/patient] seen a doctor outside the VA concerning your
(60-day survey date)
kidney problems? ---------- Yes ☐ No ☐

If Yes,

a. How many times? ----------

b. How many miles do [you/patient] travel each way, on average? miles

c. Did someone go with [you/patient] most times? ---------- ☐ yes ☐ no

6. Since _____, have [you/patient] received regular kidney dialysis treatment
(60-day survey date)
outside the VA system? ---------- Yes ☐ No ☐

If Yes,

a. How many times per week did they occur? ----------

b. How many miles each way did [you/patient] travel for treatment? miles

c. Did someone go with [you/patient] most times? ---------- ☐ yes ☐ no

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7. Since _____, have [you/patient] had medical appointments outside the VA System
(60-day survey date)
for something other than kidney problems? ---------- Yes ☐ No ☐

If Yes,

a. How many visits? ---------- ☐☐

b. How many miles each way did [you/patient] travel, on average? ☐☐☐ miles

c. Did someone go with [you/patient] most times? ---------- ☐ yes ☐ no

8. In the last week has someone helped [you/patient] around the house with healthcare, such as changing bandages or giving you medication? ---------- Yes ☐ No ☐

If yes,

a. How many hours did someone help you with healthcare last week? ☐☐☐ hours

Now I'd like to ask you about prescription medications.

9. Since _____, have you obtained a prescription at any pharmacy other than a
(60-day survey date)
VA pharmacy? ---------- Yes ☐ No ☐

If yes,

a. About how many presciptions was that? ---------- ☐☐

VA WEST HAVEN CSP530
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USE THIS PAGE TO RECORD ADDITIONAL ADMISSIONS TO HOSPITALS, NURSING HOMES, OR HOSPICE.

10. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __ (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an Intensive Care Unit? __ days

11. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __ (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an Intensive Care Unit? __ days

12. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: __ / __ / __ (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? __ days

e. For hospital stays, how many days were spent in an Intensive Care Unit? __ days

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USE THIS PAGE TO RECORD ADDITIONAL ADMISSIONS TO HOSPITALS, NURSING HOMES, OR HOSPICE.

13. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: / / (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? days

e. For hospital stays, how many days were spent in an Intensive Care Unit? days

14. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: / / (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? days

e. For hospital stays, how many days were spent in an Intensive Care Unit? days

15. Type (check one): ☐ hospital ☐ nursing home ☐ hospice

a. Admission date: / / (mm/dd/yy)

b. Facility name

c. City and state where facility located:

d. How many days were [you/patient] there? days

e. For hospital stays, how many days were spent in an Intensive Care Unit? days

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FOR STUDY COORDINATOR USE ONLY

1. Who answered the questions on this form (check one)?

☐ Study Subject

☐ Someone who lives with the subject

☐ Someone who does not live with the subject

☐ No-one

2. Were all questions answered? ☐ Yes ☐ No

If No, please give reason:

3. If the questionnaire was not completed, indicate the main reason (check one)

☐ Subject deceased and no-one esle was availabale

☐ Subject could not be contacted

☐ Subject refused to complete

☐ Subject could not complete due to illness or other reason and no-one else was available

☐ Questionnaire not administered due to institution error

☐ Other, specify

That's the end of the survey. Thank you.

Staff Initials