Annotated form 9030447478

VA WEST HAVEN CSP530
ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY)
FORM 17V - 60 DAY FOLLOW-UP FOR VA PATIENTS

Hospital | PatID | PatInits | Date

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

1. Is the patient still in the hospital for the same hospitalization during which he/she was randomized into the study? Hospitalization ☐ Yes ☐ No
   a. If yes, do not complete the remainder of this form.
   b. If no, complete remainder of this form.

Death

2. Has the patient died? ☐ Yes ☐ No
   a. If yes, date of death ☐☐ / ☐☐ / ☐☐ (mm/dd/yy) DeathDate

I am going to read you a list of questions about inpatient medical care that [you/patient] may have received outside of the VA System between _____ and _____.
(Discharge Date) (Day-60 date)

3. Between _____ and _____ , were [you/patient] admitted to any hospital outside the VA system? HospAdmit Yes ☐ No ☐
   (Discharge Date) (Day-60 date)

   If Yes,
   a. Admission date: AdmitDate ☐☐ / ☐☐ / ☐☐ (mm/dd/yy)
   b. Facility name: HospFacility
   c. City and state where facility located: HospCity HospState
   d. How many days did [you/patient] stay in that hospital? HospDays ☐☐ Days
   e. How many days were [you/patient] in the Intensive Care Unit? ICUDays ☐☐ Days
   f. Have there been additional hospital admissions? AdditionalAdmit ☐ Yes ☐ No

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

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4. Between _____ and _____ , were [you/patient] admitted to any
(Discharge Date) (Day-60 date)
nursing home outside the VA System? ---------- NursingHome ☐ Yes ☐ No

If Yes,

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

b. Facility name: NHFacility

c. City and state where facility located: NHCity NHState

d. How many days were [you/patient] in that nursing home? NHDays __ Days

e. Have there been additional nursing home admissions? NHAddAdmit ☐ Yes ☐ No

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

5. Between _____ and _____ , were [you/patient] admitted to any
(Discharge Date) (Day-60 date)
any hospice outside the VA system? ---------- Hospice ☐ Yes ☐ No

If Yes,

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

b. Facility name: HospiceFacility

c. City and state where facility located: HospiceCity HospiceState

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

e. Have there been additional hospice admissions?---------- HospiceAddAdmit ☐ Yes ☐ No

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

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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.

6. Between _____ and _____ , have [you/patient] seen a doctor
(Discharge Date) (Day-60 date)
outside the VA system concerning your kidney problems? Doctor ☐ Yes ☐ No
If Yes,
a. How many times? Appointments
b. How many miles did [you/patient] travel each way, on average? DrMilesTravel miles
c. Did someone go with [you/patient] most times? DrAlone ☐ yes ☐ no

7. Between _____ and _____ , have [you/patient] received regular
(Discharge Date) (Day-60 date)
kidney dialysis treatments outside the VA system? Dialysis ☐ Yes ☐ No
If Yes,
a. How many times per week did they occur? DialPerWeek
b. How many miles each way did [you/patient] travel for treatment? DialMilesTravel miles
c. Did someone go with [you/patient] most times? DialAlone ☐ yes ☐ no

8. . Between _____ and _____ , have [you/patient] made other trips for
(Discharge Date) (Day-60 date)
medical care outside the VA system for something other than kidney problems? MedCare ☐ Yes ☐ No
If Yes,
a. How many trips? MedCareTrips
b. How many miles each way did [you/patient] travel, on average? MedCareMiles miles
c. Did someone go with [you/patient] most times? MedCareAlone ☐ yes ☐ no

9. Between _____ and _____ , has someone helped you around
(Discharge Date) (Day-60 date)
the house with healthcare, such as changing bandages, or giving you medications? HHC ☐ Yes ☐ No
If yes,
a. How many hours per week did someone help you with healthcare? hours
HHCPerWeek

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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 FacilityType1

a. Admission date: AdmitDate1

b. Facility name AddFacility1

c. City and state where facility located: AddCity1 AddState1

d. How many days were [you/patient] there? Days1 days

e. For hospital stays, how many days were spent in an Intensive Care Unit? ICUDays1 days

11. Type (check one): ☐ hospital ☐ nursing home ☐ hospice FacilityType2

a. Admission date: / / AdmitDate2

b. Facility name AddFacility2

c. City and state where facility located: AddCity2 AddState2

d. How many days were [you/patient] there? Days2 days

e. For hospital stays, how many days were spent in an Intensive Care Unit? ICUDays2 days

12. Type (check one): ☐ hospital ☐ nursing home ☐ hospice FacilityType3

a. Admission date: / / AdmitDate3

b. Facility name AddFacility3

c. City and state where facility located: AddCity3 AddState3

d. How many days were [you/patient] there? Days3 days

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

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13. Type (check one): ☐ hospital ☐ nursing home ☐ hospice FacilityType4

a. Admission date: / / AdmitDate4

b. Facility name AddFacility4

c. City and state where facility located: AddCity4 AddState4

d. How many days were [you/patient] there? Days4 days

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

FacilityType5 ICUDays4

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

a. Admission date: / / AdmitDate5

b. Facility name AddFacility5

c. City and state where facility located: AddCity5 AddState5

d. How many days were [you/patient] there? Days5 days

e. For hospital stays, how many days were spent in an Intensive Care Unit? ICUDays5 days

15. Type (check one): ☐ hospital ☐ nursing home ☐ hospice FacilityType6

a. Admission date: / / AdmitDate6

b. Facility name AddFacility6

c. City and state where facility located: AddCity6 AddState6

d. How many days were [you/patient] there? days Days6

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

ICUDays6

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FOR STUDY COORDINATOR USE ONLY

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

☐ Study Subject

☐ Someone who lives with the subject

☐ Someone who does not live with the subject WhoAnswered

☐ No-one

AllQuestions

2. Were all questions answered? ---------- ☐ Yes ☐ No

If No, please give reason: AllQuestionsDesc

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

NotComplete

☐ Subject deceased and no-one else was available

☐ 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 NotCompleteDesc

StaffInits

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

Staff Initials