

STONE: CLINICAL SCREENING FORM

<div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin: 0 auto;">G</div> <p style="text-align: center; margin: 0;">Site</p>	Participant ID (Obtain from drug label)	<div style="border: 1px solid black; width: 100%; height: 20px; display: flex; justify-content: space-between;"> </div>
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1. Visit date (mm/dd/yyyy) SDATE	<div style="border: 1px solid black; width: 100%; height: 20px; display: flex; justify-content: space-between;"> </div>
2. Name of person completing this form _____	Initials SINITS <div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; margin-top: 5px;"> </div>

A. Demographics and Social Characteristics

3. Age SAGE	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; margin: 0 auto;"> </div> years (not eligible if < 18 years)
4. Sex SSEX	<input type="checkbox"/> ₁ Female <input type="checkbox"/> ₂ Male
5. Race/ethnicity	
a. Do you consider yourself Hispanic or Latino?	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ Unknown SETHN
b. Race (check only one) SRACE	
<input type="checkbox"/> ₁ Native American or Alaska Native	<input type="checkbox"/> ₄ Black or African-American
<input type="checkbox"/> ₂ Asian	<input type="checkbox"/> ₅ White
<input type="checkbox"/> ₃ Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> ₆ Unknown or Not Reported

B. Current Medications

6.	Are you allergic to tamsulosin SALLTAM	<input type="checkbox"/> ₀ No (or unknown) <input type="checkbox"/> ₁ Yes
7.	Do you take any medication on a regular basis?	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes SMEDS
8.	If yes, list current medications SMEDSX	
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Patient is NOT ELIGIBLE if on insulin, oral hypoglycemics, or calcium channel blockers

C. Symptoms

9.	List symptoms	Check all that apply
<input type="checkbox"/>	a. Increased need to urinate SURIN	<input type="checkbox"/> ₁
<input type="checkbox"/>	b. Urinating more often at night SURNIGHT	<input type="checkbox"/> ₁
<input type="checkbox"/>	c. Pain when urinating SPAINUR	<input type="checkbox"/> ₁
<input type="checkbox"/>	d. Feeling of not emptying bladder completely SNOTEMP	<input type="checkbox"/> ₁
<input type="checkbox"/>	e. Side pain ('Flank' pain) SSIDEP	<input type="checkbox"/> ₁
<input type="checkbox"/>	f. Nausea SNAUSEA	<input type="checkbox"/> ₁
<input type="checkbox"/>	g. Vomiting SVOMIT	<input type="checkbox"/> ₁



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9. List symptoms (continued)		Check all that apply
○	h. Dizzy	SDIZZY <input type="checkbox"/> _1
○	i. Chest pain	SCHPAIN <input type="checkbox"/> _1
○	j. Fever	SFEVER <input type="checkbox"/> _1

D. Medical History (by report)

10.	Past history of kidney stones? SHXKSTN <input type="checkbox"/> _0 No <input type="checkbox"/> _1 Yes
	If yes, SNUMSTN <input type="checkbox"/> a. How many episodes? <input type="checkbox"/> SDTSTN <input type="checkbox"/> b. Date of most recent episode <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
11.	Family history of kidney stones (parents/siblings)? SFAMHX <input type="checkbox"/> _0 No <input type="checkbox"/> _1 Yes
12.	Have you had a kidney transplant or donated a kidney? STRANSP <input type="checkbox"/> _0 No <input type="checkbox"/> _1 Yes
13.	Have you had surgery for stones in the kidney or renal system? SSURG <input type="checkbox"/> _0 No <input type="checkbox"/> _1 Yes

E. Initial Vital Signs

Initial (recorded at triage)

14.	Blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mmHg	SIBPSYS / SIBPDIA
15.	Heart rate	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bpm	SIHR
16.	RR	<input type="checkbox"/> <input type="checkbox"/>	SIRR
17.	Temperature SITEMP	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> °F (Patient not eligible if temp>101.5 °F)	

F. Urine Results

Urinalysis – dipstick:		SDIPGLUC ---- SDIPBLD ---- SDIPWBC
		<i>0</i> <i>Trace</i> <i>1+</i> <i>2+</i> <i>3+</i> <i>4+</i>
18.	Glucose	<input type="checkbox"/> _0 <input type="checkbox"/> _1 <input type="checkbox"/> _2 <input type="checkbox"/> _3 <input type="checkbox"/> _4 <input type="checkbox"/> _5
19.	Blood	<input type="checkbox"/> _0 <input type="checkbox"/> _1 <input type="checkbox"/> _2 <input type="checkbox"/> _3 <input type="checkbox"/> _4 <input type="checkbox"/> _5
20.	White cells	<input type="checkbox"/> _0 <input type="checkbox"/> _1 <input type="checkbox"/> _2 <input type="checkbox"/> _3 <input type="checkbox"/> _4 <input type="checkbox"/> _5
21.	Was an HCG done? <input type="checkbox"/> _0 No or not indicated (e.g. hysterectomy, tubal ligation, post menopause or male) <input type="checkbox"/> _1 Yes if yes, record result below SHCG	
	a. If Yes, HCG result	SHCGRES <input type="checkbox"/> _0 Negative <input type="checkbox"/> _1 Positive (not eligible)
22.	Was Urinalysis microscopy done? SMICRO <input type="checkbox"/> _0 No (If No, skip to 26) <input type="checkbox"/> _1 Yes	
	<i>none, negative, WNL</i>	<i>1-5, trace, present, slight, rare</i> <i>6-15, moderate</i> <i>16-30, many, frequent</i> <i>> 30, innumerable, TNTC</i>
23.	Blood	<input type="checkbox"/> _0 <input type="checkbox"/> _1 <input type="checkbox"/> _2 <input type="checkbox"/> _3 <input type="checkbox"/> _4 SMICBLD
24.	White cells	<input type="checkbox"/> _0 <input type="checkbox"/> _1 <input type="checkbox"/> _2 <input type="checkbox"/> _3 <input type="checkbox"/> _4 SMICWBC
25.	Bacteria	<input type="checkbox"/> _0 <input type="checkbox"/> _1 <input type="checkbox"/> _2 <input type="checkbox"/> _3 <input type="checkbox"/> _4 SMICBACT



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G. X-ray & CT scan results

For KUB:

26. Was a KUB done? (if No, skip to 31) **RKUB** ₀ No ₁ Yes

27. Was a stone noted? **RKSTONE** ₀ No stone noted ₁ Yes, one stone ₂ Yes, multiple stones

a. **If Yes**, largest dimension: mm (not eligible if larger than 9mm) **RKLARGST**

Report by radiologist (may be filled out later)

28.	"Possible stone"?	RKPOSS	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
29.	Phlebolith?	RKPHLEB	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
30.	Bilateral stones?	RKBILAT	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

For CT scan:

31.	Was a stone noted? RCTSTONE <input type="checkbox"/> ₀ No stone noted <input type="checkbox"/> ₁ Yes, one stone <input type="checkbox"/> ₂ Yes, multiple stones		
	a. If Yes , largest dimension: <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> mm (not eligible if larger than 9mm)	RLARGEST	
32.	Hydronephrosis?	RHYDRON	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
33.	Stranding?	RSTRAND	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
34.	Bilateral stones?	RBILAT	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
35.	Stone location	Check all that apply if multiple stones	
	a. Renal pelvis	RLRENPEL	<input style="width: 20px; height: 20px;" type="checkbox"/>
	b. Proximal ureter	RLPROXUR	<input style="width: 20px; height: 20px;" type="checkbox"/>
	c. Mid ureter	RLPROXUR	<input style="width: 20px; height: 20px;" type="checkbox"/>
	d. Distal ureter	RLDISTUR	<input style="width: 20px; height: 20px;" type="checkbox"/>
	e. UVJ	RLUVJ	<input style="width: 20px; height: 20px;" type="checkbox"/>
	f. Bladder	RLBLAD	<input style="width: 20px; height: 20px;" type="checkbox"/>
	g. Location not specified	RLNOTSPC	<input style="width: 20px; height: 20px;" type="checkbox"/>
36.	"Possible stone"?	RCTPOSS	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
37.	Phlebolith?	RCTPHLEB	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

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38.	Other CT findings	Check all that apply
	a. Appendicitis RCTAPPEN	<input type="checkbox"/> ₁
	b. Diverticulitis RCTDIVER	<input type="checkbox"/> ₁
	c. Inflammatory bowel disease RCTINFLA	<input type="checkbox"/> ₁
	d. Aortic aneurysm RCTAORT	<input type="checkbox"/> ₁
	e. Abdominal mass RCTABDO	<input type="checkbox"/> ₁
	f. Fibroids RCTFIBR	<input type="checkbox"/> ₁
	g. Pelvic mass RCTPELMS	<input type="checkbox"/> ₁
	h. Solitary kidney (if yes patient is not eligible) RCTSINGL	<input type="checkbox"/> ₁
	i. Other RCTOTHER i) Specify: <input style="width: 200px; height: 20px;" type="text"/>	<input type="checkbox"/> ₁

H. Blood Tests and Results

39.	Was a CBC obtained?	SCBC	<input type="checkbox"/> ₀ No	If no, skip to 41	<input type="checkbox"/> ₁ Yes
40.	Were there any abnormalities?	SCBCABN	<input type="checkbox"/> ₀ No	If no, skip to 41	<input type="checkbox"/> ₁ Yes
	If Yes, CBC abnormalities:				Check all that apply
	a. Raised WBC	SWBCABN			<input type="checkbox"/> ₁
	b. Low WBC	SWBCABN			<input type="checkbox"/> ₁
	c. Raised HCT	SHCTABN			<input type="checkbox"/> ₁
	d. Low HCT	SHCTABN			<input type="checkbox"/> ₁
	e. Raised platelets	SPLATABN			<input type="checkbox"/> ₁
	f. Low platelets	SPLATABN			<input type="checkbox"/> ₁

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41.	Was a blood chemistry obtained?	SCHEM	<input type="checkbox"/> No	If no, skip to 43	<input type="checkbox"/> Yes
42.	Were there any abnormalities?	SCHEMABN	<input type="checkbox"/> No	If no, skip to 43	<input type="checkbox"/> Yes
	If Yes, blood chemistry abnormalities:				Check all that apply
	a. Raised Na	SNAABN	<input type="checkbox"/> ₁		
	b. Low Na	SNAABN	<input type="checkbox"/> ₁		
	c. Raised K	SKABN	<input type="checkbox"/> ₁		
	d. Low K	SKABN	<input type="checkbox"/> ₁		
	e. Raised CO2	SCO2ABN	<input type="checkbox"/> ₁		
	f. Low CO2	SCO2ABN	<input type="checkbox"/> ₁		
	g. Raised BUN	SBUNABN	<input type="checkbox"/> ₁		
	h. Low BUN	SBUNABN	<input type="checkbox"/> ₁		
	i. Raised creatinine (if >2.6 in a male or 3.5 in a female, pt is not eligible)		<input type="checkbox"/> ₁		
	j. Low creatinine	SCRTABN	<input type="checkbox"/> ₁		
	k. Raised glucose	SGLUCABN	<input type="checkbox"/> ₁		
	l. Low glucose	SGLUCABN	<input type="checkbox"/> ₁		
I. Discharge from ED					
43.	Stone expelled in the ED?	SEXPEL	<input type="checkbox"/> No	<input type="checkbox"/> Yes (If yes, not eligible)	
44.	Final primary ED diagnosis	SFINDX	<input type="checkbox"/> Renal colic	<input type="checkbox"/> Nephrolithiasis	<input type="checkbox"/> Other
	a. If Other, specify:	<input style="width: 300px; height: 20px;" type="text"/>	SFINDXX		
45.	Patient admitted?	SADMIT	<input type="checkbox"/> No	<input type="checkbox"/> Yes (If yes, not eligible)	
	a. If yes , to which service?	SADMSERV	<input type="checkbox"/> Urology	<input type="checkbox"/> Surgery	<input type="checkbox"/> Medicine <input type="checkbox"/> Other
	i) If Other, specify:	<input style="width: 300px; height: 20px;" type="text"/>	SADMSRVX		

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Discharge vital signs (use last set recorded)			
46.	Blood pressure	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> mmHg </div>	SDBPSYS / SDBPDIA
47.	Heart rate	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> bpm </div>	SDHR
48.	RR	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	SDRR
49.	Temperature	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> . <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> °F </div> <p style="font-size: small; margin-top: 5px;">(Patient not eligible if temp > 101.5 °F)</p>	SDTEMP

PLEASE ENSURE THAT ALL DATA AND RADIOLOGY RESULTS HAVE BEEN RECORDED BEFORE COMPLETION OF THIS FORM

THE FOLLOWING CT SCAN QUESTIONS WERE NOT INCLUDED ON THE ORIGINAL FORM, BUT WERE KEYED IN THE DATABASE FOLLOWING THE INITIAL ENTRY.

For CT scan:			
	Side of symptomatic stone	RSIDESYM	<input style="width: 20px; height: 20px;" type="checkbox"/> 1 = Left 2 = Right
	Location of symptomatic stone	RLOCASYM	<input style="width: 20px; height: 20px;" type="checkbox"/> 1 = Renal Pelvis 2 = Proximal ureter 3 = Mid ureter 4 = Distal ureter 5 = UVJ
	Size of symptomatic stone	RSIZESYM	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> mm </div>
	Side of additional stones	RSIDELOC	<input style="width: 20px; height: 20px;" type="checkbox"/> 1 = Left 2 = Right 3 = Bilateral

END OF FORM

STONE: FOLLOW-UP FORM

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1.	Date of contact	FDATE	 / /
2.	Name of person completing this form _____	FINITS	Initials
3.	Was patient unable to be reached?	FREACH	<input type="checkbox"/> No <input type="checkbox"/> Yes

If question 3 is checked Yes, STOP.
If Day 90 contact, SKIP to question 8.

4.	Have you taken the study medication	FSTDYMED	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. How many doses since the last interview ?	FSMEDDOS	
5.	Are you taking a NSAID?	FNSAID	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. What dose? mg	FNSDOS	
	b. How many pills have you taken since the last phone contact? pills	FNSNUM	
6.	Are you taking a Percocet?	FPERC	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. What dose? mg	FPERCDOS	
	b. How many pills have you taken since the last phone contact? pills	FPERCNUM	
7.	Are you taking another analgesic?	FANALG	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. Specify: 	FANALGX	
	b. What dose? mg	FANDOS	
	c. How many pills have you taken since the last phone contact? pills	FANNUM	
8.	Are you employed?	FEMPLOYD	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. Have you returned to work?	FRETWORK	<input type="checkbox"/> No <input type="checkbox"/> Yes
9.	Have you noted any of the following?		
	a. Feeling dizzy (any time)	FDIZZY	<input type="checkbox"/> No <input type="checkbox"/> Yes
	b. Feeling dizzy on standing up	FDIZSTND	<input type="checkbox"/> No <input type="checkbox"/> Yes
	c. Burning, stinging when urinating or needing to urinate more often?		<input type="checkbox"/> No <input type="checkbox"/> Yes FURINATE
	d. Abnormalities of ejaculation	FABNEJAC	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA- female patient



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10.	Have you had a follow-up visit with a doctor for the stone?	FFUPVST	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>If yes,</p> <p>a. Name of MD: _____ b. Phone (if possible) _____</p> <p>c. Date of visit / / FFUPDATE</p> <p style="text-align: center;">FFUPSPEC</p> <p>d. Specialty: <input type="checkbox"/>₁ PCP <input type="checkbox"/>₂ Urologist <input type="checkbox"/>₃ Other i) If other, specify FFUPSPCX</p>			
11.	Have you returned to the ER because of the stone?	FRETER	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>If yes,</p> <p>a. Which ER? _____</p> <p>b. Date of visit / / FERDATE</p> <p>c. Did you have any of these procedures? <input type="checkbox"/> No <input type="checkbox"/>₁ Yes -x-rays <input type="checkbox"/>₂ Yes -CT FERXRAY FERCT</p> <p>d. Give brief narrative of reason for visit and outcome below:</p>			
12.	Have you been hospitalized because of the stone?	FHOSP	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>If yes,</p> <p>a. Which hospital? _____</p> <p>b. Date of hospitalization / / FHSPDATE</p> <p>c. How many nights did you spend in the hospital? nights FHSPNITE</p> <p>d. Give brief narrative of reason for visit and outcome below:</p>			
13.	Have you expelled the stone?	FEXPEL	<input type="checkbox"/> No <input type="checkbox"/> ₁ Seen <input type="checkbox"/> ₂ Captured
<p>If Seen or Captured,</p> <p>a. Date / / FEXPDATE</p>			
14.	Have you had or been scheduled for surgical intervention for stone?	FSURG	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>If yes,</p> <p>a. Type of procedure FSURGTYP <input type="checkbox"/>₁ Lithotripsy <input type="checkbox"/>₂ Ureteral stent <input type="checkbox"/>₃ Ureteroscopy (no stent) <input type="checkbox"/>₄ Other</p> <p>i) If Other, specify type: FSRGTYPX</p>			

END OF FOLLOW UP FORM

