

AFRICAN AMERICAN STUDY OF KIDNEY DISEASE AND HYPERTENSION
AASK COHORT STUDY
FOLLOW-UP FOR PATIENTS ON DIALYSIS OR TRANSPLANTED FORM # 129

This form is completed annually at the scheduled time of the C12, C24, C36, C48, or C60 visit for patients who are on dialysis or have a transplant. (If you have already submitted an AASK Cohort Study Death Form 148, you do not need to complete Form 129.)

Grid for Identification Number (6 boxes)

Grid for Name Code (5 boxes)

Grid for Visit Number (3 boxes)

Grid for Date of Visit (mm/dd/yyyy) (8 boxes)

1. Identification Number...

2. Name Code...

3. Visit Number...

4. Date of Visit: mm/dd/yyyy

5. Date dialysis began? (mm/dd/yyyy) ... dial - dt

6. What type of renal replacement therapy are you presently receiving? ... dial type
1=hemodialysis, 2=peritoneal dialysis-skip to Q11, 3=transplant-skip to Q13.

For Hemodialysis patients only:

7. Number of times/week you have dialysis ... dial times

8. When you started dialysis did you have:

a. A graft or fistula (usually an operation on your arm) (0=no, 1=yes) ... g-f

b. A catheter (plastic tube under your collarbone or by your neck) (0=no, 1=yes) ... catheter

9. Has anyone spoken with you about the possibility of having a kidney transplant? (0=no, 1=yes) ... transplant

10. What is the name and location of your dialysis unit? (do not enter)

11. Did you change from another mode of renal replacement therapy since your last visit? (0=no, 1=yes) ... chg - mode

12. What type of renal replacement therapy were you receiving at your last visit? ... last - dial type
1=hemodialysis, 2=peritoneal dialysis, 3=transplant

13. Date of change in therapy (mm/dd/yyyy) ... chg - dt
(If exact date is not known, use '15' for day of month.)

14. Vital status (1=alive; 2=deceased, complete the AASK Death Form 148) ... vital - stat
(If you cannot determine the patient's vital status, check with your state's department of vital statistics.)

200. Date this form completed (mm/dd/yyyy) ... Compl - dt

201. Certification ID of person completing this form ... Compl - by

For Clinical Center Use Only:

Certification ID of person entering this form: _____

Date Entered: ____/____/____