

**AFRICAN AMERICAN STUDY OF KIDNEY DISEASE AND HYPERTENSION
AASK STUDY
RENAL FAILURE FORM # 28**

This form is used to notify the DCC when any Baseline or Follow-up patient starts chronic dialysis or is transplanted, whenever the Clinical Center becomes aware of this. It is also completed when a patients' AASK GFR reveals a 50% reduction in renal function from Baseline or from one GFR to the next, if the PI would like to document cause.

When a patient in routine follow-up experiences renal failure, a Stop Point Form 30 must also be completed.

1. Identification Number.....	2. Name Code.....	3. Visit Number.....			4. Date of Visit: mm/dd/yyyy fail_dt ↑

5. Dialysis or transplant or 50% reduction in renal function? dialtran
(1=dialysis, 2=transplant, 3=50% reduction in renal function from one GFR to the next, 4=50% reduction in renal function from Baseline)

For dialysis patients only:

6. Date dialysis began (mm/dd/yyyy) / / dial_dt

7. Type of dialysis (1=Hemodialysis, 2=Peritoneal dialysis) dial type

For transplanted patients only:

8. Date of transplant (mm/dd/yyyy) / / trans_dt

9. Type of transplant: (1=living related, 2=living-unrelated, 3=cadaveric) trans type

For all patients:

10. What does the PI think caused this patient's loss of renal function? cause_rf

1=Hypertensive nephrosclerosis (as we thought when we enrolled the patient)
2=Diabetic nephropathy
3=Focal glomerulosclerosis
4=Membranoproliferative glomerulonephritis
5=Multiple myeloma
6=Allergic Interstitial Nephritis
7=Polycystic Kidney Disease
8=Reaction to contrast dye
9=unknown/none
10=Renal Artery Stenosis

(If the reason for question 10 is known but not listed, contact the DCC for a new code number.)

Renal-failure-notify

renal-failure-notfy

11. Has this patient ever had a renal biopsy? (0=no, 1=yes) ren-biop

12. If # 11 = yes, what was the date of the renal biopsy?
(mm/dd/yyyy) __/__/____ biop-dt

13. If # 11 = yes, what did the renal biopsy show? _____

_____ biop-res

Certification

201. Certification ID of person completing this form compl-b

202. Certification ID of person entering this form entr-by

For Clinical Center Use Only
Date Entered __/__/____

Verified? _____