



**ASSESS AKI  
BLOOD PRESSURE**

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Was blood pressure taken at this visit? (1000) <sub>1</sub> Yes <sub>0</sub> No
  - IF **NO**, COMPLETE QUESTION 1A AND **STOP**.
  - 1a. What was the reason blood pressure could not be taken? (1010) <sub>1</sub> Equipment failure, specify
    - \_\_\_\_\_
    - \_\_\_\_\_
    - \_\_\_\_\_
    - <sub>2</sub> Participant refusal
    - <sub>3</sub> Coordinator oversight
    - <sub>96</sub> Other \_\_\_\_\_
  
2. Time of day when seated blood pressure taken (1020)  
RECORD USING 24 HOUR **CLOCK** \_\_\_\_\_
  
3. Where was blood pressure taken? (1030)
  - <sub>1</sub> Hospital clinic visit
  - <sub>2</sub> Study/research center office
  - <sub>3</sub> Clinic visit outside hospital
  - <sub>4</sub> Home
  - <sub>96</sub> Other (SPECIFY: \_\_\_\_\_)
  
4. Blood pressure device number (1040) \_\_\_\_\_
  
5. Arm used (1050) <sub>1</sub> Right <sub>2</sub> Left
  
6. Midpoint circumference of arm used (1060) \_\_\_\_\_ . \_\_\_\_\_ cm
  
7. Size of cuff (1070)
  - <sub>1</sub> Small infant (7.0 to < 9.0 cm)
  - <sub>2</sub> Infant (9.0 to < 12.0 cm)
  - <sub>3</sub> Small child (12.0 to <16.0 cm)
  - <sub>4</sub> Child (16 to < 20.0 cm)
  - <sub>5</sub> Small adult (20.0 to < 24.0 cm)
  - <sub>6</sub> Adult (24.0 to < 33.0 cm)
  - <sub>7</sub> Large adult (33.0 to 41.0 cm)
  - <sub>8</sub> Thigh (> 41.0 cm to 50.0 cm)
  - <sub>9</sub> Thigh (> 50.0 cm)



**ASSESS AKI  
BLOOD PRESSURE**

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Have participant remain seated on a chair for 5 minutes**

8. Seated pulse measurement (# in 30 seconds X 2) (1080) \_\_\_\_\_ beats/minute
9. First seated blood pressure measure (systolic/diastolic) (1090/1100) \_\_\_\_\_ / \_\_\_\_\_ mmHg

**Wait for 30 seconds**

10. Second seated blood pressure measure (systolic/diastolic) (1110/1120) \_\_\_\_\_ / \_\_\_\_\_ mmHg

**Wait for 30 seconds**

11. Third seated blood pressure measure (systolic/diastolic) (1130/1140) \_\_\_\_\_ / \_\_\_\_\_ mmHg
12. Mean of the two lowest blood pressure measurements (1150/1160) \_\_\_\_\_ / \_\_\_\_\_ mmHg

**FOR PEDIATRIC PARTICIPANTS ONLY**

**OBTAIN BLOOD PRESSURE CHARTS APPROPRIATE FOR AGE/GENDER**

13. Record 95<sup>th</sup> percentile blood pressure measurements for age/gender/height
- 13a. systolic (1170) \_\_\_\_\_ mmHg
- 13b. diastolic (1180) \_\_\_\_\_ mmHg
14. Record percentile for participant's blood pressure measurements
- 14a. systolic (1190) \_\_\_\_\_ %
- 14b. diastolic (1200) \_\_\_\_\_ %

**Comments:**

(6000) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_







ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

## ASSESS AKI CONCOMITANT MEDICATIONS

Participant ID: \_\_ - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Please list any prescription medications, calcium, Coenzyme Q10, and vitamin D supplements the participant takes daily or regularly and has taken **within the last 30 days**. Regularly is defined as consistent frequency.

None

Record ID (1000)	Drug Code (1010)	Brand	Generic	Stop Date (1020)	Ongoing at final visit (1030)
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>
___	_____	_____	_____	___ / ___ / ___	<input type="checkbox"/> <sub>1</sub>





**AS**essment,  
**S**erial Evaluation, and  
**S**ubsequent Sequelae in AKI  
 NIH/NIDDK

ASSESS AKI  
 OVER THE COUNTER  
 CONCOMITANT  
 MEDICATIONS

Participant ID: \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

In the **past 30 days** have you taken any of the following medications daily or regularly? Regularly is defined as consistent frequency.

- 1. Aspirin (1000) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2. Fish oil supplements (1010) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know  
 (Omega-3 Oils, Omega-3 Fatty-Acids)
- 3. Non-steroidal anti-inflammatory drugs (NSAIDs) (1020) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know  
 → USE CMED\_OTC REFERENCE CARD

**Comments:**

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





**AS**essment,  
**S**erial Evaluation, and  
**S**ubsequent Sequelae in AKI  
 NIH/NIDDK

**ASSESS AKI  
 DEATH  
 RECORD  
 EVALUATION**

Participant ID: \_\_ - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Where did the participant die?

- (1040) <sub>1</sub> Inside the hospital or ER  
<sub>2</sub> Outside the hospital or ER

**Comments:**

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_









ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

## ASSESS AKI URINE DIPSTICK RESULTS

Participant ID: \_\_ - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Urine Dipstick

1a. Specific Gravity (1000) \_\_\_\_ . \_\_\_\_\_

1b. Protein (1010) <sub>1</sub> Negative  
<sub>2</sub> Trace  
<sub>3</sub> 30 (+)  
<sub>4</sub> 100 (++)  
<sub>5</sub> ≥ 300 (+++)

1c. Glucose (1020) <sub>1</sub> Negative  
<sub>2</sub> 100  
<sub>3</sub> 250  
<sub>4</sub> 500  
<sub>5</sub> ≥ 1000

1d. Ketones (1030) <sub>1</sub> Negative  
<sub>2</sub> Trace  
<sub>3</sub> 15 (small)  
<sub>4</sub> 40 (moderate)  
<sub>5</sub> 80 (large)  
<sub>6</sub> ≥ 160

1e. Leukocyte Esterase (1040) <sub>1</sub> Negative  
<sub>2</sub> Trace  
<sub>3</sub> Small  
<sub>4</sub> Moderate  
<sub>5</sub> Large

1f. Blood (1050) <sub>1</sub> Negative  
<sub>2</sub> Trace-lysed  
<sub>3</sub> Trace-intact  
<sub>4</sub> Small (+)  
<sub>5</sub> Moderate (++)  
<sub>6</sub> Large (+++)





ASsessment,  
 Serial Evaluation, and  
 Subsequent Sequelae in AKI  
 NIH/NIDDK

ASSESS AKI  
 URINE DIPSTICK  
 RESULTS

Participant ID: \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1g. Nitrites

(1060) <sub>1</sub> Pos <sub>0</sub> Neg

1h. pH level

(1070) <sub>1</sub> ≤ 5.5  
<sub>2</sub> 6.0  
<sub>3</sub> 6.5  
<sub>4</sub> 7.0  
<sub>5</sub> ≥ 7.5

**Comments:**

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





**AS**essment,  
**S**erial Evaluation, and  
**S**ubsequent Sequelae in AKI  
 NIH/NIDDK

**ASSESS AKI  
 DNA-dbGAP  
 CONSENT**

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Is this participant being re-consented? (995) <sub>1</sub> Yes <sub>0</sub> No  
 KAISER SITE: IF YES, PROCEED TO QUESTION 6.
2. Did the participant give permission to prepare DNA from his/her blood samples? (1000) <sub>1</sub> Yes <sub>0</sub> No
3. Did the participant give permission to create a cell line from his/her blood cells? (1010) <sub>1</sub> Yes <sub>0</sub> No
4. Did the participant give permission to test his/her DNA for genes related to the main goal of this study: learning the causes and effects of diseases of the kidney? (1020) <sub>1</sub> Yes <sub>0</sub> No
5. Did the participant give permission to test his/her DNA for genes related to other health conditions? (1030) <sub>1</sub> Yes <sub>0</sub> No
6. Did the participant give permission for his/her genetic data to be included in the NIH Database of Genotypes and Phenotypes (dbGAP)? (1040) <sub>1</sub> Yes <sub>0</sub> No

**Comments:**

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
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ASSESS AKI  
ECG CLINIC

Participant ID: 1 - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Was an ECG performed at this visit? (1000) <sub>1</sub> Yes <sub>0</sub> No  
 → If **NO**, COMPLETE QUESTION 1A AND **STOP**.
- 1a. What was the reason an ECG could not be performed? (1010) <sub>1</sub> Equipment failure, specify  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- <sub>2</sub> Participant refusal  
<sub>3</sub> Coordinator oversight  
<sub>96</sub> Other \_\_\_\_\_
2. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1015) <sub>1</sub> Yes <sub>0</sub> No
3. Did the ECG indicate one of the following conditions?
- 3a. Acute Myocardial Infarction or acute ischemia (1020) <sub>1</sub> Yes <sub>0</sub> No
- 3b. Ventricular Tachycardia/Ventricular Fibrillation (1030) <sub>1</sub> Yes <sub>0</sub> No
- 3c. Atrial Fibrillation (if new since previous ECG) (1040) <sub>1</sub> Yes <sub>0</sub> No
- 3d. Atrial Flutter (if new since previous ECG) (1050) <sub>1</sub> Yes <sub>0</sub> No
- 3e. Complete Atrioventricular Block (1060) <sub>1</sub> Yes <sub>0</sub> No
- 3f. Bradycardia (<45 beats/min) (1070) <sub>1</sub> Yes <sub>0</sub> No
- If **YES** TO ANY OF THE ABOVE (3a – 3f), COMPLETE THE ADULT ALERT (P1\_ALERT) FORM.
4. HeartSquare measurements
- 4a. E-measurement (1080) \_\_\_\_\_
- 4b. V6-measurement (1090) \_\_\_\_\_





ASsessment,  
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NIH/NIDDK

ASSESS AKI  
ECG CLINIC

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Comments:**

(6000) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
ECG  
FROM OTHER SOURCES

Participant ID: \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

***This form records ECGs in the inpatient and outpatient phases that were processed and provided by other sources and were not provided by the ASSESS-AKI site.***

1. Source of authorization to obtain ECG: (1000) <sub>1</sub> Consent  
<sub>2</sub> Medical records release
2. Date of ECG: (1010) \_\_\_ / \_\_\_ / \_\_\_\_\_  
MM DD YYYY

**Comments:**

(6000) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
ELIGIBILITY CHECKLIST 2

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Medical History**

1. Is the participant currently pregnant or nursing?  
CHECK N/A IF THE PARTICIPANT IS MALE. (1000) <sub>1</sub> Yes <sub>0</sub> No <sub>97</sub> N/A
2. Has the participant remained hospitalized 90 or more days  
after the AKI episode?  
CHECK N/A FOR CONTROL PARTICIPANTS. (1005) <sub>1</sub> Yes <sub>0</sub> No <sub>97</sub> N/A
3. Since the AKI episode, has the participant received prior  
hemodialysis or peritoneal dialysis lasting ≥ 3 months?  
CHECK N/A FOR CONTROL PARTICIPANTS. (1010) <sub>1</sub> Yes <sub>0</sub> No <sub>97</sub> N/A
4. Since the index hospitalization, does the participant have a  
history of solid organ and/or hematopoietic cell  
transplants? (1020) <sub>1</sub> Yes <sub>0</sub> No
5. Since the index hospitalization, does the participant have a  
history of multiple myeloma? (1030) <sub>1</sub> Yes <sub>0</sub> No
6. Since the index hospitalization, does the participant have  
hepatorenal syndrome? (1040) <sub>1</sub> Yes <sub>0</sub> No
7. Since the index hospitalization, does the participant have  
acute glomerulonephritis? (1050) <sub>1</sub> Yes <sub>0</sub> No
8. Since the index hospitalization, does the participant  
currently have clinically significant urinary tract obstruction,  
confirmed by imaging? (1060) <sub>1</sub> Yes <sub>0</sub> No
9. Does the participant have a history of metastatic  
cancer or systemic cancer and he/she is receiving  
active treatment? (1070) <sub>1</sub> Yes <sub>0</sub> No
10. Is the participant expected to live 12 months or less?  
THIS IS DETERMINED BY THE PARTICIPANT'S  
TREATING PHYSICIAN OR CLINICAL RESEARCH  
CENTER PRINCIPAL INVESTIGATOR. (1080) <sub>1</sub> Yes <sub>0</sub> No
11. Is the participant enrolled in an active interventional study  
at the 3-month visit?  
DEFINED AS RECEIVING THE STUDY INTERVENTION  
AT THE 3-MONTH VISIT. (1090) <sub>1</sub> Yes <sub>0</sub> No





Assessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

## ASSESS AKI ELIGIBILITY CHECKLIST 2

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

### Other Study Exclusion Criteria

12. Is the participant incarcerated, institutionalized, or otherwise unable to participate in the study in a home, community, or clinical setting? (1100) <sub>1</sub> Yes <sub>0</sub> No
13. Was the participant able to provide an adequate blood sample at this visit? (1110) <sub>1</sub> Yes <sub>0</sub> No <sub>97</sub> N/A  
 ADULT PARTICIPANTS SHOULD PROVIDE AT LEAST 10 ML.  
 CHECK N/A FOR PEDIATRIC PARTICIPANTS.
14. Was the participant able to provide an adequate urine sample at this visit? (1115) <sub>1</sub> Yes <sub>0</sub> No  
 ADULT PARTICIPANTS SHOULD PROVIDE AT LEAST 20 ML.  
 PEDIATRIC PARTICIPANTS SHOULD PROVIDE 1.6 ML FOR DIAPER WEARERS AND 5 ML FOR NON-DIAPER WEARERS.

15. Is the participant eligible? (1120) <sub>1</sub> Yes <sub>0</sub> No

If any of the shaded boxes are selected, the participant is ineligible.

➔ IF NO, STOP AND COMPLETE THE ASSESS AKI WITHDRAWAL (WITHDR) FORM.

### Comments:

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_









Assessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
HOSPITAL/ER  
RECORD  
EVALUATION

Participant ID: \_\_\_ - \_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

6. Were any ASSESS-AKI CPT codes identified in the hospital records? (1100) <sub>1</sub> Yes <sub>0</sub> No  
 → IF **YES**, COMPLETE THE ICD9/CPT ADMINISTRATIVE CODES (ICD9\_CPT\_CODES) SHEET
7. Were any ASSESS-AKI CCI codes identified in the hospital records? (1105) <sub>1</sub> Yes <sub>0</sub> No  
 → IF **YES**, COMPLETE THE ICD10/CCI ADMINISTRATIVE CODES (ICD10\_CCI\_CODES) SHEET
- IF ANY QUALIFYING ASSESS-AKI CODES ARE PRESENT STOP HERE AND BEGIN EVENT ADJUDICATION PROCESS. REFER TO THE EVENT ADJUDICATION PACKAGING CHECKLIST (EA\_CHK) FOR THE DOCUMENTATION NECESSARY TO ADJUDICATE THE EVENT.

(IF **NO** QUALIFYING ICD-9/ICD10 CODES ARE PRESENT: THE COORDINATOR RECORDS THE PRIMARY DISCHARGE DIAGNOSIS IN Q6000 AND THE PRINCIPAL INVESTIGATOR COMPLETES Q1110-Q1250 AND SIGNS Q6000 TO CONFIRM WHO REVIEWED THE CHART.)

8. Did any of the following occur?  
 → IF ANY EVENTS ARE CHECKED YES IN QUESTIONS 8A-8M, BEGIN EVENT ADJUDICATION PROCESS. REFER TO THE EVENT ADJUDICATION PACKAGING CHECKLIST (EA\_CHK) FOR THE DOCUMENTATION NECESSARY TO ADJUDICATE THE EVENT.
- |  |        |   |  |  |
|--|--------|---|--|--|
| 8a. Acute kidney injury                                    | (1110) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8b. Myocardial infarction                                  | (1120) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8c. Heart failure  | (1130) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8d. Ischemic stroke or transient ischemic attack           | (1140) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8e. Hemorrhagic stroke or intracranial hemorrhage          | (1150) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8f. Blockage in the arteries of the arms, legs, or abdomen | (1160) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8g. Coronary artery bypass surgery                         | (1190) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8h. Percutaneous coronary intervention                     | (1200) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8i. Peripheral artery intervention                         | (1210) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |
| 8j. Lower extremity/digit amputation                       | (1220) | <input type="checkbox"/> <sub>1</sub> Yes | <input type="checkbox"/> <sub>0</sub> No | <input type="checkbox"/> <sub>98</sub> Unknown |





**AS**essment,  
**S**erial **E**valuation, and  
**S**ubsequent **S**equelae in AKI  
 NIH/NIDDK

**ASSESS AKI  
 HOSPITAL/ER  
 RECORD  
 EVALUATION**

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

8k. Carotid artery revascularization (angioplasty, stenting, carotid endarterectomy) (1230) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Unknown

8l. Implantation of cardioverter defibrillator (1240) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Unknown

8m. Kidney transplant (1260) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Unknown

**Comments:**

(6000) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_









ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
INPATIENT SERUM  
CREATININE MEASURES

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Coordinator ID: \_\_\_\_\_

Collection Number (1000)	Collection date (1010)	Time (24-hour clock) (1020)	Serum Creatinine (1030)	Unit of Measure (1040)
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol/L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L
_____	____ / ____ / ____	_____	_____ . _____	<input type="checkbox"/> <sub>1</sub> mg/dL <input type="checkbox"/> <sub>2</sub> umol /L

Comments:

(6000) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
MODIFIED  
MINI-MENTAL  
STATE EXAM

Participant ID: 1\_ - \_\_\_\_ - \_\_\_\_\_  
Participant Initials: \_\_\_\_\_  
Visit Number: \_\_\_\_\_  
Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
Coordinator ID: \_\_\_\_\_

THIS FORM WILL BE AUDITED BY THE DCC.

TELL THE PARTICIPANT, "I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once".

1. When were you born?

1a. Month \_\_\_\_\_ (1000) <sub>1</sub> Correct <sub>0</sub> Incorrect

1b. Day \_\_\_\_\_ (1010) <sub>1</sub> Correct <sub>0</sub> Incorrect

1c. Year \_\_\_\_\_ (1020) <sub>1</sub> Correct <sub>0</sub> Incorrect

Where were you born?

1d. City/Town \_\_\_\_\_ (1030) <sub>1</sub> Correct <sub>0</sub> Incorrect

1e. State/County/Province \_\_\_\_\_ (1040) <sub>1</sub> Correct <sub>0</sub> Incorrect

**QUESTION 1 TOTAL SCORE (SUM OF 1A THROUGH 1E)** (1050) \_\_\_\_ (MAX. SCORE: 5)

2. I am going to say three words for you to remember. Repeat them after I have said all 3 words: 'socks', 'blue', 'charity'

DO NOT REPEAT THE WORDS FOR THE PARTICIPANT UNTIL AFTER THE FIRST TRIAL. THE PARTICIPANT MAY GIVE THE WORDS IN ANY ORDER. IF THERE ARE ANY ERRORS ON THE FIRST TRIAL, REPEAT THE ITEMS UP TO SIX TIMES, UNTIL THEY ARE LEARNED.

2a. Socks (1060) <sub>1</sub> Correct <sub>0</sub> Incorrect

2b. Blue (1070) <sub>1</sub> Correct <sub>0</sub> Incorrect

2c. Charity (1080) <sub>1</sub> Correct <sub>0</sub> Incorrect

NUMBER OF PRESENTATIONS NECESSARY FOR THE PARTICIPANT TO REPEAT THE SEQUENCE (1 – 6) \_\_\_\_\_

**QUESTION 2 TOTAL SCORE (SUM OF 2A THROUGH 2C)** (1090) \_\_\_\_ (MAX. SCORE: 3)



3.

3a. I would like you to count from 1 to 5.

- Able to count forward  
 Unable to count forward (Say "1, 2, 3, 4, 5")

3b. Now I would like you to count backward from 5 to 1.

- (1100)  <sub>2</sub> Accurate  
 <sub>1</sub> 1 – 2 Errors  
 <sub>0</sub> >2 Errors

RECORD THE FIRST FIVE NUMBERS IN THE  
ORDER GIVEN:

\_\_\_\_ (Participant response)  
5 4 3 2 1 (Correct order)

**QUESTION 3 TOTAL SCORE (SCORE FROM 3B ONLY)** (1110) \_\_\_\_ (MAX. SCORE: 2)

4.

4a. Spell 'world'.

- Able to spell  
 Unable to spell (Say: "It's spelled 'WORLD'.")

4b. Now spell 'world' backward.  
NUMBER OF CORRECT RESPONSES

(1120) \_\_\_\_

RECORD THE FIRST FIVE LETTERS IN THE  
ORDER GIVEN:

\_\_\_\_ (Participant response)  
D L R O W (Correct order)

**QUESTION 4 TOTAL SCORE (SCORE FROM 4B ONLY)** (1130) \_\_\_\_ (MAX. SCORE: 5)

5. What three words did I ask you to remember earlier?

THE WORDS MAY BE REPEATED IN ANY ORDER. IF THE SUBJECT CANNOT GIVE THE CORRECT ANSWER AFTER A CATEGORY CUE, PROVIDE HIM/HER WITH THE THREE CHOICES LISTED. IF THE SUBJECT STILL CANNOT GIVE THE CORRECT ANSWER FROM THE THREE CHOICES, MARK 0 AND PROVIDE THE CORRECT ANSWER.





5a. Socks

- (1140) <sub>3</sub> Spontaneous recall  
<sub>2</sub> Correct word/incorrect form  
<sub>2</sub> After "**Something to wear**"  
<sub>1</sub> After "**Was it shirt, shoes or socks?**"  
<sub>0</sub> Unable to recall/refused (provide the correct answer)

5b. Blue

- (1150) <sub>3</sub> Spontaneous recall  
<sub>2</sub> Correct word/incorrect form  
<sub>2</sub> After "**A color**"  
<sub>1</sub> After "**Was it blue, black or brown?**"  
<sub>0</sub> Unable to recall/refused (provide the correct answer)

5c. Charity

- (1160) <sub>3</sub> Spontaneous recall  
<sub>2</sub> Correct word/incorrect form  
<sub>2</sub> After "**A good, personal quality**"  
<sub>1</sub> After "**Was it honesty, charity or modesty?**"  
<sub>0</sub> Unable to recall/refused (provide the correct answer)

**QUESTION 5 TOTAL SCORE (SUM OF 5A THROUGH 5C)**

- (1170) \_\_\_\_ (MAX. SCORE: 9)



6. What is today's date?

6a. Month \_\_\_\_\_  
RECORD ANSWER VERBATIM. ENTER "X" IF NO  
RESPONSE.

- (1180) <sub>2</sub> Accurate  
<sub>1</sub> Within 1 month  
<sub>0</sub> Inaccurate

Day \_\_\_\_\_  
RECORD ANSWER VERBATIM. ENTER "X" IF NO  
RESPONSE.

- (1190) <sub>3</sub> Accurate  
<sub>2</sub> Within 2 days  
<sub>1</sub> Within 3 - 5 days  
<sub>0</sub> Inaccurate

Year \_\_\_\_\_  
RECORD ANSWER VERBATIM. ENTER "X" IF NO  
RESPONSE.

- (1200) <sub>8</sub> Accurate  
<sub>4</sub> Within 1 year  
<sub>2</sub> Within 2 - 5 years  
<sub>0</sub> Inaccurate

6b. What is the day of the week?

\_\_\_\_\_  
RECORD ANSWER VERBATIM. ENTER "X" IF NO  
RESPONSE.

- (1210) <sub>1</sub> Correct <sub>0</sub> Incorrect

6c. What season of the year is it?

\_\_\_\_\_  
RECORD ANSWER VERBATIM. ENTER "X" IF NO  
RESPONSE.

- (1220) <sub>1</sub> Correct <sub>0</sub> Incorrect

**QUESTION 6 TOTAL SCORE (SUM OF 6A (MONTH  
+ DAY + YEAR), 6B AND 6C.)**

- (1230) \_\_\_\_ (MAX. SCORE: 15)



7.

7a. What state/province are we in? (1240) <sub>2</sub> Correct <sub>0</sub> Incorrect

RECORD ANSWER VERBATIM. ENTER "X" IF NO RESPONSE.

7b. What country are we in? (1250) <sub>1</sub> Correct <sub>0</sub> Incorrect

RECORD ANSWER VERBATIM. ENTER "X" IF NO RESPONSE.

7c. What city/town are we in? (1260) <sub>1</sub> Correct <sub>0</sub> Incorrect

RECORD ANSWER VERBATIM. ENTER "X" IF NO RESPONSE.

7d. Are we in a clinic, store or home? (1270) <sub>1</sub> Correct <sub>0</sub> Incorrect

RECORD ANSWER VERBATIM. ENTER "X" IF NO RESPONSE.

**QUESTION 7 TOTAL SCORE (SUM OF 7A THROUGH 7D)** (1280) \_\_\_\_ (MAX. SCORE: 5)

8. POINT TO THE OBJECT OR A PART OF YOUR OWN BODY AND ASK THE PARTICIPANT TO NAME IT. SCORE 0 IF THE PARTICIPANT CANNOT NAME IT WITHIN 2 SECONDS OR GIVES AN INCORRECT NAME. DO NOT WAIT FOR THE PARTICIPANT TO MENTALLY SEARCH FOR THE NAME.

8a. Forehead: "What do you call this part of the face?" (1290) <sub>1</sub> Correct <sub>0</sub> Incorrect

8b. Chin: "...And this part?" (1300) <sub>1</sub> Correct <sub>0</sub> Incorrect

8c. Shoulder: "...And this part of the body?" (1310) <sub>1</sub> Correct <sub>0</sub> Incorrect

8d. Elbow: "...And this part?" (1320) <sub>1</sub> Correct <sub>0</sub> Incorrect

8e. Knuckle: "...And this part of the hand?" (1330) <sub>1</sub> Correct <sub>0</sub> Incorrect

**QUESTION 8 TOTAL SCORE (SUM OF 8A THROUGH 8E)** (1340) \_\_\_\_ (MAX. SCORE: 5)



9. What animals have four legs? Tell me as many as you can.

DISCONTINUE AFTER 30 SECONDS. COUNT ALL CORRECT RESPONSES. IF THE PARTICIPANT GIVES NO RESPONSE IN 10 SECONDS, AND THERE ARE AT LEAST 10 SECONDS OF REMAINING TIME, GENTLY REMIND (ONCE ONLY), **“What (other) animals have four legs?”** THE FIRST TIME AN INCORRECT ANSWER IS GIVEN, SAY, **“I want four-legged animals.”** DO NOT CORRECT FOR SUBSEQUENT ERRORS.

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**QUESTION 9 TOTAL SCORE**

(1350) \_\_\_\_ (MAX. SCORE: 10)

NOTE: THOUGH PARTICIPANT MAY NAME MORE THAN 10 ANIMALS IN 30 SECONDS, THE MAXIMUM SCORE IS 10. QUESTION 9 TOTAL SCORE = NUMBER OF FOUR LEGGED ANIMALS NAMED IN 30 SECONDS.

10.

10a. In what way are an arm and a leg alike?

- (1360) <sub>2</sub> Limbs, extremities
- <sub>1</sub> Lesser correct answer, e.g., body part, both bend, have joints
- <sub>0</sub> Error, e.g., states differences, gives unrelated answer/refused

IF THE SUBJECT FAILS TO GIVE AN ANSWER THAT IS WORTH 2 POINTS, MARK THE APPROPRIATE SCORE OF 1 OR 0. IF THE ANSWER IS NOT WORTH 2 POINTS, COACH THE SUBJECT BY SAYING, **“An arm and a leg are both limbs or extremities.”** DO NOT COACH FOR QUESTIONS 10b AND 10c.

10b. In what way are laughing and crying alike?

- (1370) <sub>2</sub> Expressions of feelings, emotions
- <sub>1</sub> Lesser correct answer, e.g., sounds, expressions
- <sub>0</sub> Error, e.g., states differences, gives unrelated answer/refused



10c. In what ways are eating and sleeping alike?

- (1380) <sub>2</sub> Necessary bodily functions, essential for life  
<sub>1</sub> Lesser correct answer, e.g., bodily functions, relaxing, "good for you"  
<sub>0</sub> Error, e.g., states differences, gives unrelated answer/refused

**QUESTION 10 TOTAL SCORE (SUM OF 10A THROUGH 10C)**

(1390) \_\_\_\_ (MAX. SCORE: 6)

11. Repeat what I say: 'I would like to go out'.

PRONOUNCE THE INDIVIDUAL WORDS CLEARLY, BUT WITH NORMAL TEMPO OF A SPOKEN SENTENCE.

- (1400) <sub>2</sub> Correct  
<sub>1</sub> 1 or 2 words missed  
<sub>0</sub> 3 or more words missed/refused

**QUESTION 11 TOTAL SCORE**

(1410) \_\_\_\_ (MAX. SCORE: 2)

12. Now repeat: 'No ifs, ands or buts.'

12a. no ifs

(1420) <sub>1</sub> Correct <sub>0</sub> Incorrect

12b. ands

(1430) <sub>1</sub> Correct <sub>0</sub> Incorrect

12c. or buts

(1440) <sub>1</sub> Correct <sub>0</sub> Incorrect

**QUESTION 12 TOTAL SCORE (SUM OF 12A THROUGH 12C)**

(1450) \_\_\_\_ (MAX. SCORE: 3)

13. HOLD UP THE CLOSE YOUR EYES CARD AND SAY "Please do this."

- (1460) <sub>3</sub> Closes eyes without prompting  
<sub>2</sub> Closes eyes after prompting  
<sub>1</sub> Reads aloud, but does not close eyes  
<sub>0</sub> Does not read aloud or close eyes/refused

IF THE SUBJECT DOES NOT CLOSE THEIR EYES WITHIN 5 SECONDS, PROMPT BY POINTING TO THE SENTENCE AND SAYING, "Read and do what this says." IF THE SUBJECT HAS ALREADY READ THE SENTENCE ALOUD SPONTANEOUSLY, SIMPLY SAY, "Do what this says."



ALLOW 5 SECONDS FOR THE RESPONSE. MARK 1 IF THE SUBJECT READS THE SENTENCE ALOUD, EITHER SPONTANEOUSLY OR AFTER YOUR REQUEST, BUT NOT CLOSE THEIR EYES. AS SOON AS THE SUBJECT CLOSES THEIR EYES, SAY, "Open."

**QUESTION 13 TOTAL SCORE**

(1470) \_\_\_\_ (MAX. SCORE: 3)

14. Please write the following sentence: "I would like to go out."

HAND THE SUBJECT A PIECE OF BLANK PAPER AND A #2 PENCIL WITH ERASER. IF NECESSARY, REPEAT THE SENTENCE WORD BY WORD AS THE SUBJECT WRITES. ALLOW A MAXIMUM OF 1 MINUTE AFTER THE FIRST READING OF THE SENTENCE FOR THE SECOND RESPONSE.

EITHER PRINTING OR CURSIVE WRITING IS ALLOWED. ASSIGN 1 POINT FOR EACH CORRECT WORD, BUT NO CREDIT FOR "I". FOR EACH WORD, MARK 0 IF THERE ARE SPELLING ERRORS OR INCORRECT MIXED CAPITALIZATIONS (ALL LETTERS PRINTED UPPER-CASE ARE PERMISSABLE). DO NOT PENALIZE SELF-CORRECTED ERRORS.

14a. would

(1480) <sub>1</sub> Correct <sub>0</sub> Incorrect

14b. like

(1490) <sub>1</sub> Correct <sub>0</sub> Incorrect

14c. to

(1500) <sub>1</sub> Correct <sub>0</sub> Incorrect

14d. go

(1510) <sub>1</sub> Correct <sub>0</sub> Incorrect

14e. out

(1520) <sub>1</sub> Correct <sub>0</sub> Incorrect

14f. Note which hand the subject used to write. If this is not done, ask subject if they are right or left-handed (For use in Question 16)?

Right

Left

**QUESTION 14 TOTAL SCORE (SUM OF 14A THROUGH 14E)**

(1530) \_\_\_\_ (MAX. SCORE: 5)

15. Here is a drawing. Please copy this drawing onto this piece of paper.

HAND THE SUBJECT A PIECE OF PAPER AND STIMULI CARD. FOR RIGHT-HANDED SUBJECTS, PRESENT THE SAMPLE ON THEIR LEFT SIDE. FOR LEFT-HANDED SUBJECTS, PRESENT THE SAMPLE ON THEIR RIGHT SIDE. ALLOW 1 MINUTE FOR COPYING. IN SCORING, DO NOT PENALIZE FOR LEFT-CORRECT ERRORS, TREMORS, MINOR GAPS, OR OVERSHOTS.



15a. Pentagon 1

- (1540) <sub>4</sub> 5 approximately equal sides  
<sub>3</sub> 5 sides, but longest:shortest side is 2:1  
<sub>2</sub> Non-pentagon enclosed figure  
<sub>1</sub> 2 or more lines, but not an enclosure  
<sub>0</sub> Less than 2 lines/refused

15b. Pentagon 2

- (1550) <sub>4</sub> 5 approximately equal sides  
<sub>3</sub> 5 sides, but longest:shortest side is 2:1  
<sub>2</sub> Non-pentagon enclosed figure  
<sub>1</sub> 2 or more lines, but not an enclosure  
<sub>0</sub> Less than 2 lines/refused

15c. Intersection

- (1560) <sub>2</sub> 4-cornered enclosure  
<sub>1</sub> Other than 4-cornered enclosure  
<sub>0</sub> No enclosure/refused

**QUESTIONS 15 TOTAL SCORE (SUM OF 15A THROUGH 15C)**

(1570) \_\_\_\_ (MAX. SCORE: 10)

16. REFER BACK TO QUESTION 14f TO DETERMINE THE PARTICIPANT'S DOMINANT HAND. HOLD UP A PIECE OF WHITE PAPER IN PLAIN VIEW OF THE SUBJECT, BUT OUT OF REACH, AND SAY: **"Take this paper with your left (RIGHT FOR LEFT-HANDED PERSON) hand, fold it in half and hand it back to me."**

AFTER SAYING THE WHOLE COMMAND, HOLD THE PAPER WITHIN REACH OF THE SUBJECT. DO NOT REPEAT ANY PART OF THE COMMAND. DO NOT GIVE VISUAL CLUES FOR THEM TO TAKE OR RETURN THE PAPER. HE/SHE MAY HAND IT BACK WITH EITHER HAND.

16a. Takes paper in correct hand

- (1580) <sub>1</sub> Correct <sub>0</sub> Incorrect

16b. Folds paper in half

- (1590) <sub>1</sub> Correct <sub>0</sub> Incorrect

16c. Hands paper back

- (1600) <sub>1</sub> Correct <sub>0</sub> Incorrect

**QUESTION 16 TOTAL SCORE (SUM OF 16A THROUGH 16C)**

(1610) \_\_\_\_ (MAX. SCORE: 3)



17. What three words did I ask you to remember earlier?

THE WORDS MAY BE REPEATED IN ANY ORDER. IF THE SUBJECT CANNOT GIVE THE CORRECT ANSWER AFTER A CATEGORY CUE, PROVIDE THE THREE CHOICES LISTED. IF THE SUBJECT STILL CANNOT GIVE THE CORRECT ANSWER FROM THE THREE CHOICES, MARK 0 AND PROVIDE THE CORRECT ANSWER.

17a. Socks

- (1620) <sub>3</sub> Spontaneous recall  
<sub>2</sub> Correct word/incorrect form  
<sub>2</sub> After “**Something to wear.**”  
<sub>1</sub> After “**Was it shirt, shoes or socks?**”  
<sub>0</sub> Unable to recall/refused (provide the correct answer)

17b. Blue

- (1630) <sub>3</sub> Spontaneous recall  
<sub>2</sub> Correct word/incorrect form  
<sub>2</sub> After “**A color.**”  
<sub>1</sub> After “**Was it blue, black, brown?**”  
<sub>0</sub> Unable to recall/refused (provide the correct answer)

17c. Charity

- (1640) <sub>3</sub> Spontaneous recall  
<sub>2</sub> Correct word/incorrect form  
<sub>2</sub> After “**A good, personal quality.**”  
<sub>1</sub> After “**Was it honesty, charity, modesty?**”  
<sub>0</sub> Unable to recall/refused (provide the correct answer)

**QUESTION 17 TOTAL SCORE (SUM OF 17A THROUGH 17C)**

(1650) \_\_\_\_ (MAX. SCORE: 9)





18. Special Problems?

Yes  No

18a. If **YES**, primary problem?

- Vision
- Hearing
- Inability to write due to injury/illness
- Illiteracy/lack of education
- Language (difficulty speaking/understanding English)
- Other **Specify:** \_\_\_\_\_

18b. If **YES**, Secondary problem (*specify*): \_\_\_\_\_





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Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

THIS FORM IS AUDITED BY THE DCC.

TELL THE PARTICIPANT, "Now, I would like to ask you some questions to check your memory and concentration. Please do not make any notes or write things down during this part of the interview. Some of the questions may be easy and some will be harder. Take your time if you need to. We can skip over questions if you don't understand them. Just relax and do your best.

1. Who is the president of the United States now?

- (1000) <sub>1</sub> Correct  None  
<sub>0</sub> Incorrect  Sight  
<sub>99</sub> Refused  Hearing  
 Hands  
 Other

\_\_\_\_\_  
RECORD FIRST RESPONSE

2. Who was the president before him?

- (1020) <sub>1</sub> Correct  None  
<sub>0</sub> Incorrect  Sight  
<sub>99</sub> Refused  Hearing  
 Hands  
 Other

\_\_\_\_\_  
RECORD FIRST RESPONSE

3. Who is the vice president of the United States now?

- (1040) <sub>1</sub> Correct  None  
<sub>0</sub> Incorrect  Sight  
<sub>99</sub> Refused  Hearing  
 Hands  
 Other

\_\_\_\_\_  
RECORD FIRST RESPONSE

4. Who was vice president before him?

- (1060) <sub>1</sub> Correct  None  
<sub>0</sub> Incorrect  Sight  
<sub>99</sub> Refused  Hearing  
 Hands  
 Other

\_\_\_\_\_  
RECORD FIRST RESPONSE

5. Who is the governor of (subject's state) now?

- (1080) <sub>1</sub> Correct  None  
<sub>0</sub> Incorrect  Sight  
<sub>99</sub> Refused  Hearing  
 Hands  
 Other

\_\_\_\_\_  
RECORD FIRST RESPONSE

Section Total

\_\_\_\_ out of 5





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6. Now I'm going to say three words for you to remember. Please listen carefully and repeat them after I have said all three words. Please do not write anything down. Are you ready? The three words are shirt, nickel, and honesty. HAVE RESPONDENT REPEAT. IF THERE ARE ERRORS, CONTINUE WITH ADDITIONAL TRIALS (UP TO 3 TRIALS).

	Trial 1		Trial 2	Trial 3
6a. Shirt	_____ (1100)	<input type="checkbox"/> 1 Correct <input type="checkbox"/> 0 Incorrect	_____	_____
6b. Nickel	_____ (1110)	<input type="checkbox"/> 1 Correct <input type="checkbox"/> 0 Incorrect	_____	_____
6c. Honesty	_____ (1120)	<input type="checkbox"/> 1 Correct <input type="checkbox"/> 0 Incorrect	_____	_____

6d. Score for Trial 1 \_\_\_\_  
IF PARTICIPANT REFUSED RECORD 99

6e. Impairment

- None
- Sight
- Hearing
- Hands
- Other

6f. Number of Trials needed \_\_\_\_  
ONLY ALLOW UP TO 3 TRIALS

CHECK THE BOX BELOW IF THE REMINDER WAS GIVEN TO THE PARTICIPANT

Remember the 3 words because later I will ask you to repeat them.

Section Total \_\_\_\_\_ out of 3



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Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

7. Now please count from 1 to 5.  
ASSIST ONLY ONCE IF NEEDED.

IF THE PARTICIPANT DOES NOT COMPREHEND, SCORE 0 ON BACKWARD TASK AND GO TO QUESTION 9.

7a. RECORD THE FIRST FIVE NUMBERS IN THE ORDER GIVEN:

- (1150) <sub>2</sub> Correct  
<sub>1</sub> 1 or 2 Errors  
<sub>0</sub> ≥ 3 Errors  
<sub>0</sub> Can't Do  
<sub>99</sub> Refused

\_\_\_\_ (Participant response)  
1 2 3 4 5 (Correct order)

7b. Impairment

- None  
 Sight  
 Hearing  
 Hands  
 Other

8. Now I would like you to count backwards from 5 to 1.

8a. RECORD THE FIRST FIVE NUMBERS IN THE ORDER GIVEN:

- (1170) <sub>2</sub> Correct  
<sub>1</sub> 1 or 2 Errors  
<sub>0</sub> ≥ 3 Errors  
<sub>0</sub> Can't Do  
<sub>99</sub> Refused

\_\_\_\_ (Participant response)  
5 4 3 2 1 (Correct order)

8b. Impairment

- None  
 Sight  
 Hearing  
 Hands  
 Other

Section Total

\_\_\_ out of 4





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Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

9. Please spell the word 'World'.  
ASSIST ONLY ONCE IF NEEDED. IF PARTICIPANT IS UNABLE TO SPELL WORLD DUE TO  
CONFUSION GO TO QUESTION 11.

9a. RECORD THE FIRST FIVE LETTERS IN THE  
ORDER GIVEN:

\_\_\_\_ (Participant response)  
**W O R L D** (Correct order)

9b. Number of letters in correct position (1200) \_\_\_\_ letters  
RECORD 99 IF PARTICIPANT REFUSED

9c. Impairment

- None
- Sight
- Hearing
- Hands
- Other

10. Now please spell 'World' backwards.

10a. RECORD THE FIRST FIVE LETTERS IN THE ORDER GIVEN:

\_\_\_\_ (Participant response)  
**D L R O W** (Correct order)

10b. Number of letters in correct position (1220) \_\_\_\_ letters  
RECORD 99 IF PARTICIPANT REFUSED

10c. Impairment

- None
- Sight
- Hearing
- Hands
- Other

Section Total \_\_\_\_ out of 10



**ASSESS AKI  
MODIFIED MINI-MENTAL  
STATE EXAM  
PHONE VERSION**

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

11. What were the three words that I asked you to remember?

IF THE PARTICIPANT DOES NOT GIVE ALL CORRECT ANSWERS, PROMPT AS NEEDED

			Impairment:
11a. Shirt _____	(1240)	<input type="checkbox"/> <sub>3</sub> Spontaneous recall <input type="checkbox"/> <sub>2</sub> Correct word/incorrect form <input type="checkbox"/> <sub>2</sub> After "Something to wear" RECORD: _____ <input type="checkbox"/> <sub>1</sub> After "Was it shirt, shoes or socks?" (CIRCLE WORD.) <input type="checkbox"/> <sub>0</sub> Unable to recall/refused (provide the correct answer)	<input type="checkbox"/> None <input type="checkbox"/> Sight <input type="checkbox"/> Hearing <input type="checkbox"/> Hands <input type="checkbox"/> Other
11b. Nickel _____	(1260)	<input type="checkbox"/> <sub>3</sub> Spontaneous recall <input type="checkbox"/> <sub>2</sub> Correct word/incorrect form <input type="checkbox"/> <sub>2</sub> After "Was some money" RECORD: _____ <input type="checkbox"/> <sub>1</sub> After "Was it penny, nickel, or dollar?" (CIRCLE WORD.) <input type="checkbox"/> <sub>0</sub> Unable to recall/refused (provide the correct answer)	<input type="checkbox"/> None <input type="checkbox"/> Sight <input type="checkbox"/> Hearing <input type="checkbox"/> Hands <input type="checkbox"/> Other
11c. Honesty _____	(1280)	<input type="checkbox"/> <sub>3</sub> Spontaneous recall <input type="checkbox"/> <sub>2</sub> Correct word/incorrect form <input type="checkbox"/> <sub>2</sub> After "A good, personal quality" RECORD: _____ <input type="checkbox"/> <sub>1</sub> After "Was it honesty, charity or modesty?" (CIRCLE WORD.) <input type="checkbox"/> <sub>0</sub> Unable to recall/refused (provide the correct answer)	<input type="checkbox"/> None <input type="checkbox"/> Sight <input type="checkbox"/> Hearing <input type="checkbox"/> Hands <input type="checkbox"/> Other

12. Please do not look at a calendar or a watch for the next several questions.

			Impairment
12a. What year is it? _____	(1310)	<input type="checkbox"/> <sub>3</sub> Correct <input type="checkbox"/> <sub>1</sub> Missed by 1 year <input type="checkbox"/> <sub>0</sub> Incorrect <input type="checkbox"/> <sub>99</sub> Refused	<input type="checkbox"/> None <input type="checkbox"/> Sight <input type="checkbox"/> Hearing <input type="checkbox"/> Hands <input type="checkbox"/> Other

Section Total

\_\_\_\_\_ out of 12



**ASSESS AKI  
MODIFIED MINI-MENTAL  
STATE EXAM  
PHONE VERSION**

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

12b. What is the season of the year?  
\_\_\_\_\_

- (1330)
- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> <sub>3</sub> Correct within a week        | <input type="checkbox"/> None    |
| <input type="checkbox"/> <sub>2</sub> Missed by 1 month            | <input type="checkbox"/> Sight   |
| <input type="checkbox"/> <sub>1</sub> Incorrect but names a season | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> <sub>0</sub> Incorrect                    | <input type="checkbox"/> Hands   |
| <input type="checkbox"/> <sub>0</sub> Can't do                     | <input type="checkbox"/> Other   |
| <input type="checkbox"/> <sub>99</sub> Refused                     |                                  |

APPROXIMATE DATES OF SEASONS:  
MARCH 20-JUNE 20 IS SPRING  
SEPT 23-DEC 19 IS FALL

JUNE 21- SEPT 22 IS SUMMER  
DEC 20-MAR 21 IS WINTER

12c. What day of the week is it?  
\_\_\_\_\_

- (1350)
- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> <sub>3</sub> Correct         | <input type="checkbox"/> None    |
| <input type="checkbox"/> <sub>1</sub> Missed by 1 day | <input type="checkbox"/> Sight   |
| <input type="checkbox"/> <sub>0</sub> Incorrect       | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> <sub>0</sub> Can't do        | <input type="checkbox"/> Hands   |
| <input type="checkbox"/> <sub>99</sub> Refused        | <input type="checkbox"/> Other   |

IF THE PARTICIPANT OFFERS A NUMBER OF THE DAY OF THE WEEK INSTEAD OF THE NAME, PROBE AS THIS IS UNCLEAR; SOME MAY REFER TO THE FIRST DAY OF THE WEEK AS SUNDAY WHILE OTHERS MAY REFER TO THE FIRST DAY OF THE WEEK AS MONDAY.

12d. What month is it?  
\_\_\_\_\_

- (1370)
- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> <sub>3</sub> Correct                     | <input type="checkbox"/> None    |
| <input type="checkbox"/> <sub>2</sub> Incorrect but within 3 days | <input type="checkbox"/> Sight   |
| <input type="checkbox"/> <sub>1</sub> Missed by 1 month           | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> <sub>0</sub> Incorrect                   | <input type="checkbox"/> Hands   |
| <input type="checkbox"/> <sub>0</sub> Can't do                    | <input type="checkbox"/> Other   |
| <input type="checkbox"/> <sub>99</sub> Refused                    |                                  |

12e. What is today's date?  
\_\_\_\_\_

- (1380)
- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> <sub>3</sub> Correct                    | <input type="checkbox"/> None    |
| <input type="checkbox"/> <sub>2</sub> Missed by 1 or 2 days days | <input type="checkbox"/> Sight   |
| <input type="checkbox"/> <sub>1</sub> Missed by 3-5 days         | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> <sub>0</sub> Incorrect                  | <input type="checkbox"/> Hands   |
| <input type="checkbox"/> <sub>0</sub> Can't do                   | <input type="checkbox"/> Other   |
| <input type="checkbox"/> <sub>99</sub> Refused                   |                                  |

Section Total

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**ASSESS AKI  
MODIFIED MINI-MENTAL  
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Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

12f. What state are you in?

\_\_\_\_\_

- |        |   |                                  |
|--------|---|----------------------------------|
| (1390) | <input type="checkbox"/> <sub>2</sub> Correct   | <input type="checkbox"/> None    |
|        | <input type="checkbox"/> <sub>0</sub> Incorrect | <input type="checkbox"/> Sight   |
|        | <input type="checkbox"/> <sub>0</sub> Can't do  | <input type="checkbox"/> Hearing |
|        | <input type="checkbox"/> <sub>99</sub> Refused  | <input type="checkbox"/> Hands   |
|        |   | <input type="checkbox"/> Other   |

12g. What country are you in?

\_\_\_\_\_

- |        |   |                                  |
|--------|---|----------------------------------|
| (1410) | <input type="checkbox"/> <sub>1</sub> Correct   | <input type="checkbox"/> None    |
|        | <input type="checkbox"/> <sub>0</sub> Incorrect | <input type="checkbox"/> Sight   |
|        | <input type="checkbox"/> <sub>0</sub> Can't do  | <input type="checkbox"/> Hearing |
|        | <input type="checkbox"/> <sub>99</sub> Refused  | <input type="checkbox"/> Hands   |
|        |   | <input type="checkbox"/> Other   |

12h. What town are you in?

\_\_\_\_\_

- |        |   |                                  |
|--------|---|----------------------------------|
| (1430) | <input type="checkbox"/> <sub>1</sub> Correct   | <input type="checkbox"/> None    |
|        | <input type="checkbox"/> <sub>0</sub> Incorrect | <input type="checkbox"/> Sight   |
|        | <input type="checkbox"/> <sub>0</sub> Can't do  | <input type="checkbox"/> Hearing |
|        | <input type="checkbox"/> <sub>99</sub> Refused  | <input type="checkbox"/> Hands   |
|        |   | <input type="checkbox"/> Other   |

12i. Are you in a church, a home, or an office?

\_\_\_\_\_

- |        |   |                                  |
|--------|---|----------------------------------|
| (1450) | <input type="checkbox"/> <sub>1</sub> Correct   | <input type="checkbox"/> None    |
|        | <input type="checkbox"/> <sub>0</sub> Incorrect | <input type="checkbox"/> Sight   |
|        | <input type="checkbox"/> <sub>0</sub> Can't do  | <input type="checkbox"/> Hearing |
|        | <input type="checkbox"/> <sub>99</sub> Refused  | <input type="checkbox"/> Hands   |
|        |   | <input type="checkbox"/> Other   |

IF THE CORRECT ANSWER IS NOT AMONG THE 3 CHOICES, SUBSTITUTE THE CORRECT ANSWER FOR THE THIRD CHOICE (AN OFFICE).

Section Total

\_\_\_ out of 5





**ASSESS AKI  
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Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

13. Expressive Language

13a. What do you call the part of your face that is above your eyebrows?

- (1480) <sub>1</sub> Correct (FOREHEAD/BROW)  
<sub>0</sub> Incorrect  
<sub>0</sub> Can't do  
<sub>99</sub> Refused

- Impairment  
 None  
 Sight  
 Hearing  
 Hands  
 Other

\_\_\_\_\_

13b. What do you call the pointed part of your face that is below your mouth?

- (1510) <sub>1</sub> Correct (CHIN)  
<sub>0</sub> Incorrect  
<sub>0</sub> Can't do  
<sub>99</sub> Refused

- None  
 Sight  
 Hearing  
 Hands  
 Other

\_\_\_\_\_

13c. What do you call the joint where your arm is connected to your upper body?

- (1530) <sub>1</sub> Correct (SHOULDER)  
<sub>0</sub> Incorrect  
<sub>0</sub> Can't do  
<sub>99</sub> Refused

- None  
 Sight  
 Hearing  
 Hands  
 Other

\_\_\_\_\_

13d. What do you call the joint in the middle of your arm?

- (1550) <sub>1</sub> Correct (ELBOW)  
<sub>0</sub> Incorrect  
<sub>0</sub> Can't do  
<sub>99</sub> Refused

- None  
 Sight  
 Hearing  
 Hands  
 Other

\_\_\_\_\_

13e. What do you call the joints of your fingers that you see when you make a fist?

- (1570) <sub>1</sub> Correct (KNUCKLES)  
<sub>0</sub> Incorrect  
<sub>0</sub> Can't do  
<sub>99</sub> Refused

- None  
 Sight  
 Hearing  
 Hands  
 Other

\_\_\_\_\_

Section Total

\_\_\_\_ out of 5





Assessment,  
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ASSESS AKI  
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14. Verbal Fluency

Now I am going to give you a category and I want you to name as many things as you can that come from that category. For example, if I said "fruit," you would say "orange, apple, or banana." Can you name another kind of fruit? RECORD RESPONSE.

\_\_\_\_\_

Now I have another category and it is animals. Please name as many four-legged animals as you can. You will have 20 seconds. Are you ready? START TIMER. TELL PARTICIPANT, "Begin now."  
ALLOW 20 SECONDS. IF NO RESPONSE IN 10 SECONDS, REPEAT THE QUESTION ONCE. RECORD;  
ALLOW ANOTHER 10 SECONDS THEN GO TO QUESTION 15.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of correct responses (1590) \_\_\_\_\_  
RECORD 99 IF PARTICIPANT REFUSED. MAXIMUM RESPONSE TOTAL IS 10.

15. Abstract Verbal Reasoning

15a. In what way are an arm and a leg alike?

(1610)

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> 2 Correct (BODY PART, LIMB, ETC) | <input type="checkbox"/> None    |
| <input type="checkbox"/> 1 Partly correct                 | <input type="checkbox"/> Sight   |
| <input type="checkbox"/> 0 Incorrect                      | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> 0 Can't do                       | <input type="checkbox"/> Hands   |
| <input type="checkbox"/> 99 Refused                       | <input type="checkbox"/> Other   |

\_\_\_\_\_

IF < 2-POINT RESPONSE, PROMPT THE PARTICIPANT WITH THE CORRECT RESPONSE.  
CHECK THE BOX BELOW IF THE PROMPT WAS GIVEN TO THE PARTICIPANT

Both are limbs or body parts.

Section Total \_\_\_\_\_ out of 12





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- 15b. In what way are laughing and crying alike? (1630) <sub>2</sub> Correct (EXPRESSION OF FEELING EMOTIONS, ETC)  None  
 NO PROMPT ALLOWED. <sub>1</sub> Partly correct  Sight  
<sub>0</sub> Incorrect  Hearing  
<sub>0</sub> Can't do  Hands  
<sub>99</sub> Refused  Other
- 15c. In what ways are eating and breathing alike? (1650) <sub>2</sub> Correct (ESSTL FOR LIFE)  None  
 NO PROMPT ALLOWED. <sub>1</sub> Partly correct  Sight  
<sub>0</sub> Incorrect  Hearing  
<sub>0</sub> Can't do  Hands  
<sub>99</sub> Refused  Other
- 15d. Please repeat what I say exactly. "The band played and the crowd cheered." (1670) <sub>2</sub> Correct  None  
<sub>1</sub> 1-2 missed/wrong words  Sight  
<sub>0</sub> Incorrect  Hearing  
<sub>0</sub> Can't do  Hands  
<sub>99</sub> Refused  Other

IF ALL CORRECT, MAKE CHECK MARK. IF INCORRECT, WRITE FULL RESPONSE. REPEAT IF NECESSARY. SCORE BEST RESPONSE.

TRIAL 1 \_\_\_\_\_

TRAIL 2 \_\_\_\_\_

- 15e. Now again repeat what I say exactly, "No ifs, ands, or buts." <sub>1</sub> No ifs  None  
<sub>1</sub> Ands  Sight  
<sub>1</sub> Or buts  Hearing  
 IF ALL CORRECT, MAKE CHECK MARK. IF INCORRECT, WRITE FULL RESPONSE. REPEAT IF NECESSARY. SCORE BEST RESPONSE. (1690) Total Score \_\_\_\_  Hands  
<sub>0</sub> Incorrect  Other  
<sub>0</sub> Can't do  
<sub>99</sub> Refused

TRIAL 1 \_\_\_\_\_

TRAIL 2 \_\_\_\_\_

Section Total \_\_\_\_\_ out of 9



**ASSESS AKI  
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Participant Initials: \_\_\_\_\_

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Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

15f. With your finger, please tap 5 times on the part of the phone you speak into.

- (1710)
- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> <sub>3</sub> Obeys without prompting | <input type="checkbox"/> None    |
| <input type="checkbox"/> <sub>2</sub> Obeys after prompting   | <input type="checkbox"/> Sight   |
| <input type="checkbox"/> <sub>1</sub> Says aloud only         | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> <sub>0</sub> Incorrect               | <input type="checkbox"/> Hands   |
| <input type="checkbox"/> <sub>0</sub> Can't do                | <input type="checkbox"/> Other   |
| <input type="checkbox"/> <sub>99</sub> Refused                |                                  |

15g. Do you have a rotary phone or touch tone phone? I'm going to give you some instructions, please wait until I'm finished before you begin—Ready? Please tap 3 times on the part of the phone you speak into, (press/dial) the number 1 and then say, "I'm done."

- (1730)
- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> <sub>1</sub> Taps phone          | <input type="checkbox"/> None    |
| <input type="checkbox"/> <sub>1</sub> Press/dial number 1 | <input type="checkbox"/> Sight   |
| <input type="checkbox"/> <sub>1</sub> Says I'm done       | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> <sub>0</sub> No response         | <input type="checkbox"/> Hands   |
| <input type="checkbox"/> Total score: ____                | <input type="checkbox"/> Other   |
| <input type="checkbox"/> <sub>0</sub> Can't do            |                                  |
| <input type="checkbox"/> <sub>99</sub> Refused            |                                  |

"IF P. ASKS YOU TO REPEAT THE NUMBER THEY SHOULD PRESS, TELL THEM "WHATEVER NUMBER YOU REMEMBER"

15h. Please say a complete sentence. ALLOW 10 SECONDS THEN PROMPT (IF NECESSARY). IF P. DOESN'T RESPOND OR SEEMS CONFUSED, SAY: "A sentence has to express a complete thought and has a subject and a verb"

- (1750)
- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> <sub>5</sub> Correct sentence                    | <input type="checkbox"/> None    |
| <input type="checkbox"/> <sub>4</sub> Sentence with error(s)              | <input type="checkbox"/> Sight   |
| <input type="checkbox"/> <sub>3</sub> Correct sentence after prompt       | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> <sub>2</sub> Sentence with error(s) after prompt | <input type="checkbox"/> Hands   |
| <input type="checkbox"/> <sub>1</sub> Incomplete sentence after prompt    | <input type="checkbox"/> Other   |
| <input type="checkbox"/> <sub>0</sub> No response/Can't do                |                                  |
| <input type="checkbox"/> <sub>99</sub> Refused                            |                                  |

RECORD SENTENCE: \_\_\_\_\_

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**ASSESS AKI  
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16. Please do not look at a clock for the next several questions. I'm going to ask you to picture a clock in your mind and to imagine that you're facing the clock. Then I will give you different times of the day and ask you what numbers the minute hand and hour hand are on.

Let's do an example. For 3 o'clock, the minute hand (that's the big hand) is on the 12 and the hour hand (that's the little hand) is on the 3. I will also ask you to tell me which side of the clock the hands are pointing to. For 3 o'clock, the minute hand is at the top and the hour hand is at the right.

16a. For seven o'clock

16ai. What number is the minute hand pointing to? (1770) <sub>0</sub> 12  
 SCORE AS "0" <sub>0</sub> Other (SPECIFY: \_\_\_\_\_)  
<sub>99</sub> Refused (SPECIFY: \_\_\_\_\_)

16a.ii. What number is the hour hand pointing to? (1780) <sub>1</sub> 7  
<sub>0</sub> Other (SPECIFY: \_\_\_\_\_)  
<sub>99</sub> Refused (SPECIFY: \_\_\_\_\_)

16a.iii. Is the minute hand pointing to the top or the bottom of the clock? (1790) <sub>0</sub> Top  
 SCORE AS "0" <sub>0</sub> Bottom  
<sub>99</sub> Refused

16a.iv. Is the hour hand pointing to the left or the right side of the clock? (1800) <sub>1</sub> Left  
<sub>0</sub> Right  
<sub>99</sub> Refused

16a.v. Impairment  None  
 Sight  
 Hearing  
 Hands  
 Other

IF PARTICIPANT MISSES ALL ITEMS IN Q16AI THROUGH Q16AIV, ASSIGN A SCORE OF "0" FOR ITEMS Q16B AND Q16C AND CONTINUE WITH QUESTION 17.

Section Total (1820) \_\_\_\_ out of 2



**ASSESS AKI  
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16b. For twenty minutes after eight

16bi. What number is the minute hand pointing to?

- (1830) <sub>1</sub> 4  
<sub>0</sub> Other (SPECIFY: \_\_\_\_\_)  
<sub>99</sub> Refused (SPECIFY: \_\_\_\_\_)

16bii. What number is the hour hand pointing to?

- (1840) <sub>1</sub> 8  
<sub>0</sub> Other (SPECIFY: \_\_\_\_\_)  
<sub>99</sub> Refused (SPECIFY: \_\_\_\_\_)

16biii. Is the minute hand pointing to the left or the right of the clock?

- (1850) <sub>1</sub> Right  
<sub>0</sub> Left  
<sub>99</sub> Refused

16biv. Is the hour hand pointing to the left or the right side of the clock?

- (1860) <sub>1</sub> Left  
<sub>0</sub> Right  
<sub>99</sub> Refused

16c. For ten minutes after eleven

16ci. What number is the minute hand pointing to?

- (1870) <sub>1</sub> 2  
<sub>0</sub> Other (SPECIFY: \_\_\_\_\_)  
<sub>99</sub> Refused (SPECIFY: \_\_\_\_\_)

16cii. What number is the hour hand pointing to?

- (1880) <sub>1</sub> 11  
<sub>0</sub> Other (SPECIFY: \_\_\_\_\_)  
<sub>99</sub> Refused (SPECIFY: \_\_\_\_\_)

16ciii. Is the minute hand pointing to the left or the right of the clock?

- (1890) <sub>1</sub> Right  
<sub>0</sub> Left  
<sub>99</sub> Refused

16civ. Is the hour hand pointing to the left or the right side of the clock?

- (1900) <sub>1</sub> Left  
<sub>0</sub> Right  
<sub>99</sub> Refused

Section Total

(1910) \_\_\_\_ out of 8



**ASSESS AKI  
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Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

17. What were the three words I asked you to remember? (SHIRT, NICKEL, HONESTY)  
IF THE PARTICIPANT DOES NOT GIVE ALL CORRECT ANSWERS, PROMPT AS NEEDED.

			Impairment
17a. Shirt	(1920)	<input type="checkbox"/> <sub>3</sub> Spontaneous recall	<input type="checkbox"/> None
_____		<input type="checkbox"/> <sub>2</sub> One of the words was something you wear (RECORD: _____)	<input type="checkbox"/> Sight
		<input type="checkbox"/> <sub>1</sub> PROVIDE 3 CHOICES AND HAVE PARTICIPANT MAKE SELECTION: Was one of the words shoes, shirt, or socks? (CIRCLE WORD.)	<input type="checkbox"/> Hearing
		IF STILL INCORRECT RESPONSE, PROVIDE CORRECT ANSWER.	<input type="checkbox"/> Hands
		<input type="checkbox"/> <sub>0</sub> No recall/can't do	<input type="checkbox"/> Other
		<input type="checkbox"/> <sub>99</sub> Refused	
17b. Nickel	(1940)	<input type="checkbox"/> <sub>3</sub> Spontaneous recall	<input type="checkbox"/> None
_____		<input type="checkbox"/> <sub>2</sub> One of the words was some money (RECORD: _____)	<input type="checkbox"/> Sight
		<input type="checkbox"/> <sub>1</sub> PROVIDE 3 CHOICES AND HAVE PARTICIPANT MAKE SELECTION: Was one of the words penny, nickel, or dollar? (CIRCLE WORD)	<input type="checkbox"/> Hearing
		IF STILL INCORRECT RESPONSE, PROVIDE CORRECT ANSWER.	<input type="checkbox"/> Hands
		<input type="checkbox"/> <sub>0</sub> No recall/can't do	<input type="checkbox"/> Other
		<input type="checkbox"/> <sub>99</sub> Refused	
17c. Honesty	(1960)	<input type="checkbox"/> <sub>3</sub> Spontaneous recall	<input type="checkbox"/> None
_____		<input type="checkbox"/> <sub>2</sub> One of the words was a good personal quality (RECORD: _____)	<input type="checkbox"/> Sight
		<input type="checkbox"/> <sub>1</sub> PROVIDE 3 CHOICES AND HAVE PARTICIPANT MAKE SELECTION: Was one of the words honesty, charity, or modesty? (CIRCLE WORD)	<input type="checkbox"/> Hearing
		IF STILL INCORRECT RESPONSE, PROVIDE CORRECT ANSWER.	<input type="checkbox"/> Hands
		<input type="checkbox"/> <sub>0</sub> No recall/can't do	<input type="checkbox"/> Other
		<input type="checkbox"/> <sub>99</sub> Refused	

Section Total \_\_\_\_\_ out of 9

**Comments:**

(6000) : \_\_\_\_\_





ASsessment,  
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NIH/NIDDK

ASSESS AKI  
MODIFIED MINI-MENTAL  
STATE EXAM  
TALLY SHEET

Participant ID: 1\_ - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

Question Number	Maximum Score	Annotation #/Total	
Question 1 Total (Q1050 on MMMSE)	5	(1000)	___
Question 2 Total (Q1090 on MMMSE)	3	(1010)	___
Question 3 Total (Q1110 on MMMSE)	2	(1020)	___
Question 4 Total (Q1130 on MMMSE)	5	(1030)	___
Question 5 Total (Q1170 on MMMSE)	9	(1040)	___
Question 6 Total (Q1230 on MMMSE)	15	(1050)	___
Question 7 Total (Q1280 on MMMSE)	5	(1060)	___
Question 8 Total (Q1340 on MMMSE)	5	(1070)	___
Question 9 Total (Q1350 on MMMSE)	10	(1080)	___
Question 10 Total (Q1390 on MMMSE)	6	(1090)	___
Question 11 Total (Q1410 on MMMSE)	2	(1100)	___
Question 12 Total (Q1450 on MMMSE)	3	(1110)	___
Question 13 Total (Q1470 on MMMSE)	3	(1120)	___
Question 14 Total (Q1530 on MMMSE)	5	(1130)	___
Question 15 Total (Q1570 on MMMSE)	10	(1140)	___
Question 16 Total (Q1610 on MMMSE)	3	(1150)	___
Question 17 Total (Q1650 on MMMSE)	9	(1160)	___







ASsessment,  
Serial Evaluation, and  
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NIH/NIDDK

ASSESS AKI  
MODIFIED MINI-MENTAL  
STATE EXAM PHONE  
TALLY SHEET

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

Question Number	Maximum Score	Annotation #/Total	
Page 1 Total	5	(1000)	___
Page 2 Total	3	(1010)	___
Page 3 Total	4	(1020)	___
Page 4 Total	10	(1030)	___
Page 5 Total	12	(1040)	___
Page 6 Total	12	(1050)	___
Page 7 Total	5	(1060)	___
Page 8 Total	5	(1070)	___
Page 9 Total	12	(1080)	___
Page 10 Total	9	(1090)	___
Page 11 Total	11	(1100)	___
Page 12 Total	2	(1110)	___
Page 13 Total	8	(1120)	___
Page 14 Total	9	(1130)	___





**AS**essment,  
**S**erial **E**valuation, and  
**S**ubsequent **S**equelae in AKI  
 NIH/NIDDK

**ASSESS AKI  
 OUTPATIENT  
 VASCULAR PROCEDURE  
 EVALUATION**

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

- 1. Since the participant's last ASSESS AKI study contact, what number of percutaneous coronary interventions (PCI) has he/she had? (1000) \_\_\_\_\_
  
- 2. Date of first PCI (1010) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY
  
- 3. Date of second PCI (1020) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY
  
- 4. Date of third PCI (1030) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

**Comments:**

(6000) : \_\_\_\_\_





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
ADULT  
ALERT

Participant ID: 1 - \_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Date of Alert Value (s):

(1000) \_\_\_ / \_\_\_ / \_\_\_\_\_  
MM DD YYYY

**Type of Alert Event(s):**

2. Was the alert due to a change in blood pressure?

(1010) <sub>1</sub> Yes <sub>0</sub> No

➔ If YES:

2a. Systolic blood pressure > 180

(1020) <sub>1</sub> Yes <sub>0</sub> No

2b. Diastolic blood pressure > 110

(1030) <sub>1</sub> Yes <sub>0</sub> No

3. Was the alert due to acute distress?

(1040) <sub>1</sub> Yes <sub>0</sub> No

➔ If YES:

3a. Chest pain

(1050) <sub>1</sub> Yes <sub>0</sub> No

3b. Severe Respiratory Distress

(1060) <sub>1</sub> Yes <sub>0</sub> No

3c. Acute Neurological Symptoms

(1070) <sub>1</sub> Yes <sub>0</sub> No

3d. Other

(1080) <sub>1</sub> Yes <sub>0</sub> No

➔ If YES: SPECIFY \_\_\_\_\_

**Type of Alert Value(s):**

4. Was the alert due to laboratory results?

(1090) <sub>1</sub> Yes <sub>0</sub> No

➔ If YES:

4a. Potassium  $\leq$  3.0 mEq/L ( $\leq$  3.0 mmol/L) or  $\geq$  6 mEq/L  
( $\geq$  6.0 mmol/L)

(1100) <sub>1</sub> Yes <sub>0</sub> No

4b. Sodium < 125 mEq/L (< 125 mmol/L) or > 155 mEq/L  
(> 155 mmol/L)

(1110) <sub>1</sub> Yes <sub>0</sub> No

4c. Glucose < 50 mg/dL (< 2.75 mmol/L) or > 350 mg/dL  
(> 19.25 mmol/L)

(1130) <sub>1</sub> Yes <sub>0</sub> No

4d. Creatinine doubling from last value

(1140) <sub>1</sub> Yes <sub>0</sub> No

4e. CBC Hemoglobin < 10 gm/dL (< 100 g/L)

(1150) <sub>1</sub> Yes <sub>0</sub> No





**AS**essment,  
**S**erial Evaluation, and  
**S**ubsequent Sequelae in AKI  
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**ASSESS AKI  
ADULT  
ALERT**

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

4f. Other abnormal lab value (1160) <sub>1</sub> Yes <sub>0</sub> No

→ If **YES**: SPECIFY \_\_\_\_\_

5. Was the alert due to ECG results? (1170) <sub>1</sub> Yes <sub>0</sub> No  
→ If **YES**:

5a. Date of Reading: (1180) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

5b. Type of Reading: (1190) <sub>1</sub> Local <sub>0</sub> Central

5c. Results:

5ci. Bradycardia (<45 beats/min) (1200) <sub>1</sub> Yes <sub>0</sub> No

5cii. Tachycardia (>120 beats/min) (1210) <sub>1</sub> Yes <sub>0</sub> No

5ciii. Acute Myocardial Infarction or acute ischemia (1220) <sub>1</sub> Yes <sub>0</sub> No

5civ. Ventricular Tachycardia/Ventricular Fibrillation (1230) <sub>1</sub> Yes <sub>0</sub> No

5cv. Atrial Fibrillation (1240) <sub>1</sub> Yes <sub>0</sub> No

5cvi. Atrial Flutter (1250) <sub>1</sub> Yes <sub>0</sub> No

5cvii. Mobitz Type II 2<sup>nd</sup> degree Heart Block (1260) <sub>1</sub> Yes <sub>0</sub> No

5cviii. 3<sup>rd</sup> degree Heart Block (1270) <sub>1</sub> Yes <sub>0</sub> No

5cix. Complete Left Bundle Branch Block (1280) <sub>1</sub> Yes <sub>0</sub> No

6. Was study site PI notified? (1290) <sub>1</sub> Yes <sub>0</sub> No

7. What action was taken? (1300) <sub>1</sub> Primary MD notified  
<sub>2</sub> Report sent to primary MD  
<sub>3</sub> Transferred to ER  
<sub>4</sub> Admitted to hospital  
<sub>5</sub> No action taken  
<sub>96</sub> Other \_\_\_\_\_





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ASSESS AKI  
 ADULT  
 ALERT

Participant ID: 1 - \_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

8. Participant notified of outcome?

(1310) <sub>1</sub> Yes <sub>0</sub> No <sub>97</sub> N/A

**Comments:**

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





ASsessment,  
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NIH/NIDDK

ASSESS AKI  
ADULT  
MEDICAL EVENT  
QUESTIONNAIRE

Participant ID: 1 - \_\_\_\_ - \_\_\_\_  
Participant Initials: \_\_\_\_  
Visit Number: \_\_\_\_  
Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Coordinator ID: \_\_\_\_

DO NOT ENTER. FOR REFERENCE PURPOSES ONLY.

RECORD THE DATE OF THE PARTICIPANT'S LAST  
ASSESS AKI STUDY CONTACT.

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

1. Since your last ASSESS AKI study contact, have you been hospitalized or gone to the emergency room for any medical problems? (1000) <sub>1</sub> Yes <sub>0</sub> No

➔ IF NO, PROCEED TO QUESTION 3

➔ IF YES, RECORD THE NUMBER OF ER VISITS/HOSPITALIZATIONS FOR EACH EVENT

1a. Heart attack (acute myocardial infarction, MI) (1010) <sub>1</sub> Yes <sub>0</sub> No

1ai. IF YES: Number of ER Visits/Hospitalizations (1020) \_\_\_\_\_

1b. Chest pain (angina, unstable angina, angina pectoris) (1030) <sub>1</sub> Yes <sub>0</sub> No

1bi. IF YES: Number of ER Visits/Hospitalizations (1040) \_\_\_\_\_

1c. Heart failure or fluid in the lungs (congestive heart failure, CHF) (1050) <sub>1</sub> Yes <sub>0</sub> No

1ci. IF YES: Number of ER Visits/Hospitalizations (1060) \_\_\_\_\_

1d. Heart by-pass surgery (coronary artery by-pass surgery, CABG) (1070) <sub>1</sub> Yes <sub>0</sub> No

1di. IF YES: Number of ER Visits/Hospitalizations (1080) \_\_\_\_\_

1e. Abnormal heart rhythm (heart arrhythmia) (1090) <sub>1</sub> Yes <sub>0</sub> No

1ei. IF YES: Number of ER Visits/Hospitalizations (1100) \_\_\_\_\_

1f. Stroke, mini-stroke (TIA) or brain attack, bleeding in the brain (hemorrhagic stroke, intracranial hemorrhage) (1110) <sub>1</sub> Yes <sub>0</sub> No

1fi. IF YES: Number of ER Visits/Hospitalizations (1120) \_\_\_\_\_





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ASSESS AKI  
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MEDICAL EVENT  
QUESTIONNAIRE

Participant ID: 1 - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1g. Sudden inability to speak or sudden weakness on one side of the body (1130) <sub>1</sub> Yes <sub>0</sub> No

1gi. IF YES: Number of ER Visits/Hospitalizations (1140) \_\_\_\_\_

1h. Kidney transplant (1150) <sub>1</sub> Yes <sub>0</sub> No

1hi. IF YES: Number of ER Visits/Hospitalizations (1160) \_\_\_\_\_

1i. Blockage in the arteries in your arms, legs or abdomen (peripheral vascular disease) (1170) <sub>1</sub> Yes <sub>0</sub> No

1ii. IF YES: Number of ER Visits/Hospitalizations (1180) \_\_\_\_\_

1j. Blockage in blood vessels in your neck (carotid artery disease) (1190) <sub>1</sub> Yes <sub>0</sub> No

1ji. IF YES: Number of ER Visits/Hospitalizations (1200) \_\_\_\_\_

1k. Other medical condition(s) or problem(s) (1210) <sub>1</sub> Yes <sub>0</sub> No

1ki. IF YES: Number of ER Visits/Hospitalizations (1220) \_\_\_\_\_

2. If any events are checked in Questions 1a – 1k, record the number of separate hospitalizations/ER visits since the last ASSESS AKI study contact. (1230) \_\_\_\_\_

→ COMPLETE THE EVENT INFORMATION (EVENT\_INFO) SHEET

→ COMPLETE THE HOSPITAL/ER RECORD EVALUATION (HOSP\_EVAL) FORM FOR EACH HOSPITALIZATION/ER VISIT EXCEPT WHEN DEATH OCCURS OUTSIDE OF THE HOSPITAL AND IS REPORTED BY PROXY.





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NIH/NIDDK

ASSESS AKI  
ADULT  
MEDICAL EVENT  
QUESTIONNAIRE

Participant ID: 1 - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

3. Since the last ASSESS AKI study contact, have you had any of the tests or procedures described below?

3a. Surgery (amputation, or other surgery), balloon angioplasty or amputation of limb due to blockage in blood vessels in the arms, legs, or abdomen (1250) <sub>1</sub> Yes <sub>0</sub> No

→ IF YES: Indicate where surgery or angioplasty was performed (1260) <sub>1</sub> Inpatient  
<sub>2</sub> Outpatient  
<sub>3</sub> Both

3b. Surgery (carotid endarterectomy) or balloon angioplasty to open a blockage in blood vessels in the neck (1270) <sub>1</sub> Yes <sub>0</sub> No

→ IF YES: Indicate where surgery or angioplasty was performed (1280) <sub>1</sub> Inpatient  
<sub>2</sub> Outpatient  
<sub>3</sub> Both

4. If any tests or procedures are checked in Questions 3a – 3b, record the number of separate test/procedures since the last ASSESS-AKI study contact. (1290) \_\_\_\_\_

- COMPLETE THE EVENT INFORMATION (EVENT\_INFO) SHEET
- IF INPATIENT, COMPLETE THE HOSPITAL/ER RECORD EVALUATION (HOSP\_EVAL) FORM FOR EACH TEST/PROCEDURE
- IF OUTPATIENT, COMPLETE THE PROCEDURE INVESTIGATION (PI) FORM FOR EACH PROCEDURE

5. Since the last ASSESS AKI study contact, have you had any of the tests or procedures described below?

5a. Coronary angiography (cardiac catheterization) (1310) <sub>1</sub> Yes <sub>0</sub> No

→ IF YES: Indicate where angiography was performed (1320) <sub>1</sub> Inpatient  
<sub>2</sub> Outpatient  
<sub>3</sub> Both

5ai. Did you also have a balloon angioplasty or stenting to open a blockage in blood vessels in the heart (1330) <sub>1</sub> Yes <sub>0</sub> No

→ IF YES: Indicate where angioplasty or stenting was performed (1340) <sub>1</sub> Inpatient  
<sub>2</sub> Outpatient  
<sub>3</sub> Both







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ASSESS AKI  
ADULT  
MEDICAL EVENT  
QUESTIONNAIRE

Participant ID: 1 - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

6. If any tests or procedures are checked in Questions 5a-5ai, record the number of separate test/procedures since the last ASSESS AKI study contact. (1350) \_\_\_\_\_

- ➔ COMPLETE THE EVENT INFORMATION (EVENT\_INFO) SHEET
- ➔ IF INPATIENT, COMPLETE THE HOSPITAL/ER RECORD EVALUATION (HOSP\_EVAL) FORM FOR EACH TEST/PROCEDURE
- ➔ IF OUTPATIENT, COMPLETE THE OUTPATIENT VASCULAR PROCEDURE EVALUATION (OUTPT\_VASC) FORM

7. Since the last ASSESS AKI study contact, have you had any treatments described below?

7a. Hemodialysis or peritoneal dialysis (treatment with an artificial kidney) (1370) <sub>1</sub> Yes <sub>0</sub> No

➔ IF YES: Indicate where dialysis was performed (1380) <sub>1</sub> Inpatient  
<sub>2</sub> Outpatient  
<sub>3</sub> Both

8. If any tests or procedures are checked in Question 7a, record the number of separate treatments since the last ASSESS AKI study contact. (1390) \_\_\_\_\_

- ➔ COMPLETE THE EVENT INFORMATION (EVENT\_INFO) SHEET
- ➔ IF INPATIENT, COMPLETE THE HOSPITAL/ER RECORD EVALUATION (HOSP\_EVAL) FORM FOR EACH TEST/PROCEDURE
- ➔ IF OUTPATIENT, COMPLETE THE DIALYSIS EVALUATION (DIAL\_EVAL) FORM

Research Coordinator Completed

Death (as reported by: \_\_\_\_\_) (1400) <sub>1</sub>

Record date deceased (1410) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

➔ If death reported, please complete the ASSESS AKI Withdrawal (WITHDR) form and Death Record Evaluation (DEATH\_EVAL) form.





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ASSESS AKI  
ADULT  
MEDICAL EVENT  
QUESTIONNAIRE

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Comments**

(6000): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





ASsessment,  
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NIH/NIDDK

ASSESS AKI  
ADULT  
LIFESTYLE  
VISIT 3M

Participant ID: 1 - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Coordinator ID: \_\_\_\_\_

**DO NOT ENTER. FOR REFERENCE PURPOSES ONLY.**

RECORD THE DATE OF THE PARTICIPANT'S LAST ASSESS AKI STUDY VISIT.

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**Smoking History**

Since your last ASSESS AKI study visit:

1. Have you smoked any cigarettes? (1000) <sub>1</sub> Yes <sub>0</sub> No  
➔ IF NO, PROCEED TO QUESTION 6.
2. Have you smoked more than 100 cigarettes (approximately 5 packs)? (1010) <sub>1</sub> Yes <sub>0</sub> No
3. Do you smoke cigarettes now? (1020) <sub>1</sub> Yes <sub>0</sub> No
4. How many cigarettes do you or did you usually smoke per day since your last ASSESS AKI study visit? (1030) \_\_\_\_ . \_\_\_\_ cigs/day
5. How many months did you smoke this amount? ENTER 98 IF THE PARTICIPANT DOESN'T KNOW. (1040) \_\_\_\_ months
6. Have you smoked cigars? (1050) <sub>1</sub> Yes <sub>0</sub> No  
➔ IF NO, PROCEED TO QUESTION 11.
7. Have you smoked at least 20 cigars? (1060) <sub>1</sub> Yes <sub>0</sub> No
8. Do you currently smoke cigars? (1070) <sub>1</sub> Yes <sub>0</sub> No
9. How many cigars do you or did you usually smoke per day since your last ASSESS AKI study visit? (1080) \_\_\_\_ . \_\_\_\_ cigars/day
10. How many months did you smoke this amount? ENTER 98 IF THE PARTICIPANT DOESN'T KNOW. (1090) \_\_\_\_ months





ASsessment,  
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ASSESS AKI  
ADULT  
LIFESTYLE  
VISIT 3M

Participant ID: 1 - \_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

11. Have you ever smoked a tobacco pipe regularly for at least one year? (1100) <sub>1</sub> Yes <sub>0</sub> No  
(HERE "REGULARLY" MEANS AT LEAST TWO PIPEFULS OF TOBACCO A WEEK, ALMOST EVERY WEEK.)  
➔ IF NO, PROCEED TO QUESTION 18.
12. How old were you when you started smoking a pipe regularly? (1110) \_\_\_ \_\_\_ years old
13. Do you still smoke a pipe regularly? (1120) <sub>1</sub> Yes <sub>0</sub> No  
➔ IF NO, PROCEED TO QUESTION 16.
14. Altogether, how many years have you smoked a pipe regularly? (1130) \_\_\_ \_\_\_ . \_\_\_ years
15. How many pipefuls of tobacco do you regularly smoke per day, on the average? (1140) \_\_\_ \_\_\_ pipefuls  
(IF LESS THAN 1 PER DAY, RECORD 00)  
➔ PROCEED TO QUESTION 18.
16. How many years ago did you stop? (1150) \_\_\_ \_\_\_ . \_\_\_ years
17. How many pipefuls did you usually smoke before you stopped? (1160) \_\_\_ \_\_\_ pipefuls  
(IF LESS THAN 1 PER DAY, RECORD 00)

**Alcohol Use History**

Since your last ASSESS AKI study visit:

18. Have you had at least one alcoholic drink? (1170) <sub>1</sub> Yes <sub>0</sub> No  
➔ IF NO, PROCEED TO QUESTION 23.



**FOR QUESTIONS 19 THROUGH 22, AN ALCOHOLIC DRINK CAN BE:**



**12 ounce can of beer OR**



**5 ounce glass of wine OR**



**1 shot of liquor**

19. How often have you had an alcoholic drink?

CHOOSE ONLY ONE RESPONSE.

➔ USE REFERENCE CARD A

(1180)

- <sub>1</sub> Every day
- <sub>2</sub> 5 to 6 times a week
- <sub>3</sub> 3 to 4 times a week
- <sub>4</sub> 2 times a week
- <sub>5</sub> 1 time a week
- <sub>6</sub> 2 to 3 times a month
- <sub>7</sub> 1 time a month
- <sub>8</sub> 3 to 11 times since your last clinic visit
- <sub>9</sub> 1 or 2 times since your last clinic visit
- <sub>99</sub> Don't wish to answer

20. On the days you drank, how many alcoholic drinks did you usually have?

➔ USE REFERENCE CARD B

(1190)

- <sub>1</sub> 25 or more drinks
- <sub>2</sub> 19 to 24 drinks
- <sub>3</sub> 16 to 18 drinks
- <sub>4</sub> 12 to 15 drinks
- <sub>5</sub> 9 to 11 drinks
- <sub>6</sub> 7 to 8 drinks
- <sub>7</sub> 5 to 6 drinks
- <sub>8</sub> 3 to 4 drinks
- <sub>9</sub> 2 drinks
- <sub>10</sub> 1 drink
- <sub>99</sub> Don't wish to answer





12 ounce can of beer OR



5 ounce glass of wine OR



1 shot of liquor

21. What was the largest number of alcoholic drinks that you had in a 24-hour period? (1200)  
→ USE REFERENCE CARD B
- <sub>1</sub> 25 or more drinks
  - <sub>2</sub> 19 to 24 drinks
  - <sub>3</sub> 16 to 18 drinks
  - <sub>4</sub> 12 to 15 drinks
  - <sub>5</sub> 9 to 11 drinks
  - <sub>6</sub> 7 to 8 drinks
  - <sub>7</sub> 5 to 6 drinks
  - <sub>8</sub> 3 to 4 drinks
  - <sub>9</sub> 2 drinks
  - <sub>10</sub> 1 drink
  - <sub>99</sub> Don't wish to answer
22. Since your last ASSESS AKI study visit: (1210)
- 22a. **For men**, how often did you have 5 or more alcoholic drinks within a two-hour period?  
CHOOSE ONLY ONE RESPONSE.  
→ USE REFERENCE CARD C
- <sub>1</sub> Every day
  - <sub>2</sub> 5 to 6 times a week
  - <sub>3</sub> 3 to 4 times a week
  - <sub>4</sub> 2 times a week
  - <sub>5</sub> 1 time a week
  - <sub>6</sub> 2 to 3 times a month
  - <sub>7</sub> 1 time a month
  - <sub>8</sub> 3 to 11 times since your last clinic visit
  - <sub>9</sub> 1 or 2 times since your last clinic visit
  - <sub>98</sub> N/A
  - <sub>99</sub> Don't wish to answer



22b. **For women**, how often did you have 4 or more alcoholic drinks within a two-hour period? (1220)  
CHOOSE ONLY ONE RESPONSE.  
→ USE REFERENCE CARD C

- <sub>1</sub> Every day
- <sub>2</sub> 5 to 6 times a week
- <sub>3</sub> 3 to 4 times a week
- <sub>4</sub> 2 times a week
- <sub>5</sub> 1 time a week
- <sub>6</sub> 2 to 3 times a month
- <sub>7</sub> 1 time a month
- <sub>8</sub> 3 to 11 times since your last clinic visit
- <sub>9</sub> 1 or 2 times since your last clinic visit
- <sub>98</sub> N/A
- <sub>99</sub> Don't wish to answer

**Recreational Drug Use History**

Since your last ASSESS AKI study visit:

23. Have you used marijuana? (1230)

- <sub>1</sub> Yes
- <sub>0</sub> No
- <sub>98</sub> Don't know
- <sub>99</sub> Don't wish to answer

23a. IF **YES**: Have you used marijuana within the past 30 days? (1240)

- <sub>1</sub> Yes
- <sub>0</sub> No
- <sub>98</sub> Don't know
- <sub>99</sub> Don't wish to answer

24. Have you used methamphetamines? (1250)

- <sub>1</sub> Yes
- <sub>0</sub> No
- <sub>98</sub> Don't know
- <sub>99</sub> Don't wish to answer

24a. IF **YES**: Have you used them within the past 30 days? (1260)

- <sub>1</sub> Yes
- <sub>0</sub> No
- <sub>98</sub> Don't know
- <sub>99</sub> Don't wish to answer





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ASSESS AKI  
ADULT  
LIFESTYLE  
VISIT 3M

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

25. Have you used cocaine? (1270) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

25a. IF **YES**: Have you used cocaine within the past 30 days? (1280) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

26. Have you used heroin? (1290) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

26a. IF **YES**: Have you used heroin within the past 30 days? (1300) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

27. Have you used other street drugs? (1310) <sub>1</sub> Yes  
SPECIFY: \_\_\_\_\_  
\_\_\_\_\_  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

27a. IF **YES**: Have you used other street drugs within the past 30 days? (1320) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

**Health Insurance**

28. Since your last ASSESS AKI study visit, have any changes occurred in your healthcare coverage? (1330) <sub>1</sub> Yes <sub>0</sub> No  
➔IF **NO**, PROCEED TO QUESTION 33.







ASsessment,  
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ASSESS AKI  
ADULT  
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VISIT 3M

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

29. (FOR US SITES ONLY) What type of healthcare coverage do you have?  
PLEASE ANSWER YES OR NO TO EACH TYPE OF HEALTHCARE COVERAGE.

➔ USE REFERENCE CARD D

- 29a. Uninsured (1340) <sub>1</sub> Yes <sub>0</sub> No
- 29b. Self-insured (1350) <sub>1</sub> Yes <sub>0</sub> No
- 29c. COBRA (1360) <sub>1</sub> Yes <sub>0</sub> No
- 29d. Commercial/fee-for-service (1370) <sub>1</sub> Yes <sub>0</sub> No
- 29e. HMO (1380) <sub>1</sub> Yes <sub>0</sub> No
- 29f. Local/state insurance (1390) <sub>1</sub> Yes <sub>0</sub> No
- 29g. Military (1400) <sub>1</sub> Yes <sub>0</sub> No
- 29h. Medicare (1410) <sub>1</sub> Yes <sub>0</sub> No
- 29i. Medicaid (1420) <sub>1</sub> Yes <sub>0</sub> No
- 29j. Self-pay (1430) <sub>1</sub> Yes <sub>0</sub> No
- 29k. Other \_\_\_\_\_ (1440) <sub>1</sub> Yes <sub>0</sub> No

30. (FOR CANADIAN SITES ONLY) What type of healthcare coverage do you have?  
PLEASE ANSWER YES OR NO TO EACH TYPE OF HEALTHCARE COVERAGE.

- 30a. Provincial/Public Health Insurance (1450) <sub>1</sub> Yes <sub>0</sub> No
- 30b. Private/Personal insurance (1460) <sub>1</sub> Yes <sub>0</sub> No





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Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

31. Since your last ASSESS AKI study visit, was there ever a time when you were not covered by health insurance? (1470) <sub>1</sub> Yes <sub>0</sub> No
- ➔ IF **YES**: Were you not covered by health insurance for one month or more? (1480) <sub>1</sub> Yes <sub>0</sub> No
32. Since your last ASSESS AKI study visit, were you denied health insurance? (1490) <sub>1</sub> Yes <sub>0</sub> No
33. Since your last ASSESS AKI study visit, were you unable to fill a prescription because of the cost? (1500) <sub>1</sub> Yes <sub>0</sub> No
34. Since your last ASSESS AKI study visit, were you unable to see your doctor because of the cost? (1510) <sub>1</sub> Yes <sub>0</sub> No

For Research Coordinator use only:

Where was CRF completed? (1520) <sub>1</sub> At home  
<sub>2</sub> In-clinic  
<sub>3</sub> On the phone

Who completed the CRF? (1530) <sub>1</sub> Participant completed  
<sub>2</sub> Interviewer completed

IF **PARTICIPANT COMPLETED**: Did Research Coordinator review the CRF with the participant during the in-person visit? (1540) <sub>1</sub> Yes <sub>0</sub> No

IF **YES**: Signature of Research Coordinator (1550) \_\_\_\_\_

IF **YES**: Date Signature Completed (1560) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**Comments:**

(6000): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





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ASSESS AKI  
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HISTORY

Participant ID: 1 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DO NOT ENTER. FOR REFERENCE PURPOSES ONLY.**

RECORD THE DATE OF THE PARTICIPANT'S LAST ASSESS AKI VISIT.

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

1. Since your last ASSESS AKI visit, were you diagnosed or treated by a doctor or other health professional for cancer (excluding non-melanoma skin cancer)? (1000) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- ➔ IF NO, PROCEED TO QUESTION 2.
- 1a. Did you receive chemotherapy? (1010) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- ➔ IF YES: Did you receive?
- 1ai. cisplatin (1020) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 1a.ii. ifosfamide (1030) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 1a.iii. methotrexate (1040) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 1a.iv. gemcitabine (gemzar) (1050) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 1a.v. bevacizumab (avastin) (1060) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
2. Since your last ASSESS AKI visit, were you diagnosed or treated by a doctor or other health professional for any of the following conditions?
- 2a. Asthma or reactive airway disease (1070) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2b. Chronic obstructive pulmonary disease (emphysema or chronic bronchitis) (1080) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2c. Hepatitis (B or C) infection (1090) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2d. Rheumatoid arthritis (1100) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2e. Gout (1110) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2f. Systemic lupus (1120) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know





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ASSESS AKI  
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HISTORY

Participant ID: 1 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

→ IF PARTICIPANT IS **MALE**, PROCEED TO QUESTION 5.

**Women's Health History**

Since your last ASSESS AKI visit:

3. Were you pregnant in the time period? (1130) <sub>1</sub> Yes <sub>0</sub> No  
→ IF **NO**, PROCEED TO QUESTION 4.

3a. Are you currently pregnant? (1140) <sub>1</sub> Yes <sub>0</sub> No

AT V3M ONLY, QUESTION 4 AND 4B SHOULD BE ANSWERED BASED ON THE TIME PERIOD BEFORE ENROLLMENT IN THE STUDY AND THE CURRENT VISIT DATE.

4. Did you complete menopause (no menstrual period for 1 year)? (1150) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

4a. Do you know when your last menstrual period started? (1160) <sub>1</sub> Yes <sub>0</sub> No

→ IF **YES**: record the date. (1170) \_\_\_\_ month  
MM

(1172) \_\_\_\_ year  
YYYY

4b. Did you have a hysterectomy? (1175) <sub>1</sub> Yes <sub>0</sub> No

**Renal History**

Since your last ASSESS AKI visit:

5. Did you see a nephrologist/kidney doctor *for your kidney problems*? (1180) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

6. Did you see any other doctor or health professional(s) (e.g. internist, family practitioner, hypertension specialist) *for your kidney problems*? (1190) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

→ IF YOU ANSWERED **NO** TO BOTH QUESTIONS 5 AND 6, PROCEED TO QUESTION 10.

**The following questions address any healthcare you have received since your last ASSESS AKI visit. Please provide a response for each item listed below.**

7. Was the level of protein in your urine measured? (1200) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know





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8. Was your kidney function measured by a 24-hour urine test or I-iothalamate clearance test? (1210) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
9. Did you have a kidney xray (KUB)? (1220) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
10. Did you have any vaccinations to lower your risk of infection? (1230) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 10a. IF **YES**: did you have one or more vaccines to prevent bacterial infection? (e.g. pneumovax) (1240) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 10b. IF **YES**: did you have a flu vaccine? (1250) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

**Hypertension History**

Since your last ASSESS AKI visit:

11. How long has it been since you last had your blood pressure taken by a doctor or other health professional? (1260) \_\_\_\_ \_\_\_\_
- IF PARTICIPANT DOES NOT KNOW, RECORD 98. (1270) <sub>1</sub> months  
<sub>2</sub> weeks  
<sub>3</sub> days  
<sub>97</sub> N/A
12. Did a doctor or other health professional tell you for the first time that you have hypertension or high blood pressure? (1280) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 12a. IF **YES**: do you currently take prescribed medication for your hypertension or high blood pressure? (1290) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

**High Cholesterol History**

Since your last ASSESS AKI visit:

13. How long has it been since you last had your blood cholesterol taken by a doctor or other health professional? (1300) \_\_\_\_ \_\_\_\_
- IF PARTICIPANT DOES NOT KNOW, RECORD 98. (1310) <sub>1</sub> months  
<sub>2</sub> weeks  
<sub>3</sub> days  
<sub>97</sub> N/A



14. Did a doctor or other health professional tell you for the first time that your blood cholesterol level was high? (1320) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

14a. IF **YES**: do you currently take prescribed medication for your high blood cholesterol? (1330) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

**Diabetic History**

15. Have you ever been told (except during pregnancy) that you have diabetes or high blood sugar? (1335) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

➔ IF **NO**, STOP HERE.

16. Since your last ASSESS AKI visit, did a doctor or other health professional tell you for the first time (except during pregnancy) that you have diabetes or high blood sugar? (1340) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

17. Are you currently taking insulin? (1350) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

18. Are you currently taking injectable drugs, other than insulin, to manage your blood sugar? (1360) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

19. Do you currently take diabetes pills to lower your blood sugar? (These are sometimes called oral agents or oral hypoglycemic agents.) (1370) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

20. Since your last ASSESS AKI visit, did you have your eyes examined by a doctor? (1380) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

➔ IF **YES**, record the examination date.

(1390) \_\_\_\_ month  
MM

(1395) \_\_\_\_ year  
YYYY

21. Since your last ASSESS AKI visit, did a doctor tell you that diabetes has affected your eyes or that you have retinopathy? (1400) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know





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Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

22. Do you currently have any of these problems:

22a. Numbness or tingling in your hands or feet (other than falling asleep because you laid on your arm or leg) (1410) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

22b. Loss of sensation in your hands or feet (1420) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

22c. Decreased ability to feel the hotness or coldness of things you touch (1430) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

22d. Sores or ulcers on your feet or ankles (1440) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

For Research Coordinator use only:

Where was the CRF completed? (1450) <sub>1</sub> At home  
<sub>2</sub> In-clinic  
<sub>3</sub> On the phone

Who completed the CRF? (1460) <sub>1</sub> Participant completed  
<sub>2</sub> Interviewer completed

IF **PARTICIPANT COMPLETED**: Did Research Coordinator review the CRF with the participant during the in-person visit? (1470) <sub>1</sub> Yes <sub>0</sub> No

IF **YES**: Signature of Research Coordinator (1480) \_\_\_\_\_

IF **YES**: Date Signature Completed (1490) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**Comments:**

(6000) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





ASsessment,  
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## ASSESS AKI ADULT OUTPATIENT DEMOGRAPHIC INFORMATION

Participant ID: 1 - \_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. What is your current marital status?

- (1000) <sub>1</sub> Never married  
<sub>2</sub> Currently married  
<sub>3</sub> Domestic partner  
<sub>4</sub> Separated  
<sub>5</sub> Divorced  
<sub>6</sub> Widowed  
<sub>99</sub> Don't wish to answer

2. What are your current living arrangements?

- (1010) <sub>1</sub> Live alone  
<sub>2</sub> Live with others

3. What is the type of residence?

- (1020) <sub>1</sub> Home/apartment  
<sub>2</sub> Nursing home  
<sub>3</sub> Assisted living facility  
<sub>4</sub> Rehabilitation or skilled nursing facility

4. What is your current primary employment status?

→ IF ON TEMPORARY MEDICAL LEAVE, PROCEED TO QUESTION 5.

→ IF HIGH SCHOOL STUDENT, POST HIGH SCHOOL STUDENT, NEVER WORKED OR DON'T WISH TO ANSWER, PROCEED TO QUESTION 6.

→ USE REFERENCE CARD A

- (1030) <sub>1</sub> Employed part-time  
<sub>2</sub> Employed full-time  
<sub>3</sub> High school student  
<sub>4</sub> Post high school student  
<sub>5</sub> Temporarily laid off/on strike  
<sub>6</sub> On temporary medical leave  
<sub>7</sub> Permanently disabled  
<sub>8</sub> Retired, not currently working  
<sub>9</sub> Full-time home maker  
<sub>10</sub> Unemployed  
<sub>11</sub> Never worked  
<sub>99</sub> Don't wish to answer

4a. If **not** currently employed, when was the last time you were employed?

RESPONSE SHOULD BE WRITTEN AS DATE MM/YYYY.

(1040) \_\_\_ month  
MM

(1050) \_\_\_ year  
YYYY

→ IF PARTICIPANT CANNOT REMEMBER THE MONTH OR YEAR RECORD 98 FOR MONTH AND/OR 9898 FOR YEAR







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ASSESS AKI  
ADULT OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 1 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

5. What type of work do you/did you primarily do?  
→ USE REFERENCE CARD B

- (1060) <sub>1</sub> Professional, executive occupation, business owner  
<sub>2</sub> Manager, technical occupation  
<sub>3</sub> Clerical, sales, administrative support occupation, technician  
<sub>4</sub> Skilled labor (e.g. certified electrician, carpenter, welder)  
<sub>5</sub> Semi-skilled labor (e.g. construction help, mechanic's help)  
<sub>6</sub> Other labor (e.g. porters, bell hops, manual labor)  
<sub>7</sub> Home maker  
<sub>96</sub> Other (SPECIFY WORK: \_\_\_\_\_)  
<sub>99</sub> Don't wish to answer

6. What is your total annual gross household income?  
→ USE REFERENCE CARD C

- (1070) <sub>1</sub> \$20,000 or under  
<sub>2</sub> \$20,001 – \$35,000  
<sub>3</sub> \$35,001 – \$50,000  
<sub>4</sub> \$50,001 – \$100,000  
<sub>5</sub> More than \$100,000  
<sub>99</sub> Don't wish to answer

For Research Coordinator use only:

Where was the CRF completed?

- (1080) <sub>1</sub> At home  
<sub>2</sub> In-clinic  
<sub>3</sub> On the phone

Who completed the CRF?

- (1090) <sub>1</sub> Participant completed  
<sub>2</sub> Interviewer completed





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ASSESS AKI  
 ADULT OUTPATIENT  
 DEMOGRAPHIC  
 INFORMATION

Participant ID: 1 - \_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

IF **PARTICIPANT COMPLETED**: Did Research Coordinator review the CRF with the participant during the in-person visit?

(1100) <sub>1</sub> Yes <sub>0</sub> No

IF **YES**: Signature of Research Coordinator

(1110) \_\_\_\_\_

IF **YES**: Date Signature Completed

(1120) \_\_\_ / \_\_\_ / \_\_\_\_\_  
 MM DD YYYY

**Comments:**

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





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ASSESS AKI  
ADULT  
OUTPATIENT V3M  
SPECIMEN COLLECTION:  
BLOOD

Participant ID: 1 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Coordinator ID: \_\_\_\_\_

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) <sub>1</sub> Yes <sub>0</sub> No

**Blood Specimen Collection**

RECORD ALL TIMES USING A 24-HOUR CLOCK.

2. Date of blood collection: (1010) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

3. Time of blood collection: (1020) \_\_\_\_\_

4. Was the minimum amount (10ml) of blood collected? (1030) <sub>1</sub> Yes <sub>0</sub> No

- ➔ **IF NO**, RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THIS COLLECTION AND COMPLETE THE OUTPATIENT V3M SPECIMEN 2+ COLLECTION: BLOOD (P1\_V3M\_COLLECT\_BLD\_2) FORM.
- ➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER V3M WITHIN THE VISIT WINDOW.
- ➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT 3M CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE AND COMPLETE THE ASSESS-AKI WITHDRAWAL (WITHDR) FORM

5. Were the following vacutainers collected?

Priority order	Specimen type	Vacutainer volume	
1	Serum (red)	9 mL SST or 7.5 mL double SST	(1040) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
2	Serum (red)	9 mL SST or 7.5 mL double SST	(1050) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
3	EDTA (purple)	3 mL to LOCAL LAB	(1060) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
4	EDTA (purple)	10 mL for PLASMA and DNA	(1070) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
5	EDTA (purple)	10 mL for PLASMA and DNA	(1080) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
6	Citrate (blue)	4.5 mL	(1090) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No

- ➔ IF ONE 10ML EDTA PURPLE TOP VACUTAINER WAS NOT COLLECTED WITHIN THE VISIT 3M WINDOW, PREPARE TO ATTEMPT THE DNA COLLECTION AT V12M.
- ➔ COMPLETE THE SITE SPECIFIC WORKSHEET.





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ASSESS AKI  
ADULT  
OUTPATIENT V3M  
SPECIMEN COLLECTION:  
BLOOD

Participant ID: 1 - \_ \_ - \_ \_ \_ \_ \_

Participant Initials: \_ \_ \_ \_ \_

Visit Number: 3 M

Visit Date: \_ \_ / \_ \_ / \_ \_ \_ \_ \_

Coordinator ID: \_ \_ \_ \_ \_

Comments:

(6000) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





Assessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
ADULT  
OUTPATIENT V3M  
SPECIMEN 2+  
COLLECTION: BLOOD

Participant ID: 1\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Participant Initials: \_\_\_\_\_  
Visit Number: 3\_M  
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
Coordinator ID: \_\_\_\_\_

1. (FOR HOME VISIT SITES ONLY) Was the collection completed in the participant's home? (1000) <sub>1</sub> Yes <sub>0</sub> No

**Blood Specimen Collection**

RECORD ALL TIMES USING A 24-HOUR CLOCK.

2. Date of blood collection: (1010) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

3. Time of blood collection: (1020) \_\_\_\_

4. Was the minimum amount (10ml) of blood collected between the initial collection(s) and this collection? (1030) <sub>1</sub> Yes <sub>0</sub> No

- IF NO, RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THE INITIAL COLLECTION.
- IF NO, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER V3M WITHIN THE VISIT WINDOW.
- IF NO, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT 3M CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE AND COMPLETE THE ASSESS-AKI WITHDRAWAL (WITHDR) FORM

5. Were the following vacutainers collected?

Priority order	Specimen type	Vacutainer volume	
1	Serum (red)	9 mL SST or 7.5 mL double SST	(1040) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
2	Serum (red)	9 mL SST or 7.5 mL double SST	(1050) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
3	EDTA (purple)	3 mL to LOCAL LAB	(1060) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
4	EDTA (purple)	10 mL for PLASMA and DNA	(1070) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
5	EDTA (purple)	10 mL for PLASMA and DNA	(1080) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
6	Citrate (blue)	4.5 mL	(1090) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No

- IF ONE 10ML EDTA PURPLE TOP VACUTAINER WAS NOT COLLECTED WITHIN THE VISIT 3M WINDOW, PREPARE TO ATTEMPT THE DNA COLLECTION AT V12M.
- COMPLETE THE SITE SPECIFIC WORKSHEET.





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ASSESS AKI  
 ADULT  
 OUTPATIENT V3M  
 SPECIMEN 2+  
 COLLECTION: BLOOD

Participant ID: 1 - \_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

Comments:

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_











Assessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
ADULT  
OUTPATIENT V3M  
SPECIMEN PROCESSING

Participant ID: 1 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Participant Initials: \_\_\_\_  
Visit Number: 3 M  
Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Coordinator ID: \_\_\_\_

**Blood Specimen Processing**

1. Are there any blood samples to be processed? (1000) <sub>1</sub> Yes <sub>0</sub> No  
 → IF NO, COMPLETE THE SITE SPECIFIC WORKSHEET AND PROCEED TO QUESTION 8.
  
2. How many 1.0 mL aliquots of serum were produced from 9 mL SST or 7.5 mL double SST red top vacutainers? (ASSESS-AKI goal 5 X 1.0 mL) (1010) \_\_\_\_ aliquots
  - 2a. If greater than 5 aliquots, estimate the volume of additional serum saved (REPORT TO THE NEAREST ML. IF Q1010 = 5 AND NO ADDITIONAL SERUM SAVED, RECORD 0 IN Q1020.) (1020) \_\_\_\_ mL
  
3. How many 1.0 mL aliquots of plasma were produced from 10 mL EDTA purple top vacutainers? (ASSESS-AKI goal 5 X 1.0 mL) (1030) \_\_\_\_ aliquots
  - 3a. If greater than 5 aliquots, estimate the volume of additional plasma saved. (REPORT TO THE NEAREST ML. IF Q1030 = 5 AND NO ADDITIONAL PLASMA SAVED, RECORD 0 IN Q1040.) (1040) \_\_\_\_ mL
  
4. How many packed cell pellets were produced from the 10 mL purple top vacutainers? (1 per tube, ASSESS-AKI goal 2) (1045) \_\_\_\_ pellets
  
5. How many 1.0 mL aliquots were produced from the 4.5 mL citrate blue top vacutainer? (ASSESS-AKI goal 2 X 1.0 mL) (1050) \_\_\_\_ aliquots
  - 5a. If greater than 2 aliquots, estimate the volume of additional plasma saved. (REPORT TO THE NEAREST ML. IF Q1050 = 2 AND NO ADDITIONAL PLASMA SAVED, RECORD 0 IN Q1060.) (1060) \_\_\_\_ mL
  
6. Date samples frozen (1070) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 MM DD YYYY
  
7. Time samples frozen (1080) \_\_\_\_





Assessment,  
Serial Evaluation, and  
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NIH/NIDDK

ASSESS AKI  
ADULT  
OUTPATIENT V3M  
SPECIMEN PROCESSING

Participant ID: 1 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Participant Initials: \_\_\_\_  
Visit Number: 3 M  
Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Coordinator ID: \_\_\_\_

**Urine Specimen Processing**

8. Are there any urine samples to be processed? (1090) <sub>1</sub> Yes <sub>0</sub> No  
 → IF NO, COMPLETE SITE SPECIFIC WORKSHEET AND PROCEED TO BIOLOGICAL SAMPLE TRACKING MODULE.
9. How many 1.0 mL aliquots of urine were produced? (1100) \_\_\_\_ aliquots  
 (ASSESS-AKI goal 10 X 1.0 mL)
10. How many 10 mL aliquots of urine were produced? (1110) \_\_\_\_ aliquots  
 (ASSESS-AKI goal – 3 X 10 mL)
11. How many 10 mL aliquots of urine with protease inhibitors were produced? (1120) \_\_\_\_ aliquots  
 (ASSESS AKI goal – 1 X 10 mL)
12. Date samples frozen (1130) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 MM DD YYYY
13. Time samples frozen (1140) \_\_\_\_  
 (Aliquots should be stored in a -80 freezer)

Comments:

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





Assessment,  
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NIH/NIDDK

ASSESS AKI  
ADULT  
OUTPATIENT V3M  
SPECIMEN PROCESSING  
2+

Participant ID: 1 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Participant Initials: \_\_\_\_  
Visit Number: 3 M  
Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Coordinator ID: \_\_\_\_

1. Date of collection: (995) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**Blood Specimen Processing**

2. Are there any blood samples to be processed? (1000) <sub>1</sub> Yes <sub>0</sub> No  
➔ IF NO, COMPLETE THE SITE SPECIFIC WORKSHEET AND PROCEED TO QUESTION 9.

3. How many 1.0 mL aliquots of serum were produced from 9 mL SST or 7.5 mL double SST red top vacutainers? (ASSESS-AKI goal 5 X 1.0 mL) (1010) \_\_\_\_ aliquots

3a. If greater than 5 aliquots, estimate the volume of additional serum saved (1020) \_\_\_\_ mL  
(REPORT TO THE NEAREST ML. IF Q1010 = 5 AND NO ADDITIONAL SERUM SAVED, RECORD 0 IN Q1020.)

4. How many 1.0 mL aliquots of plasma were produced from 10 mL EDTA purple top vacutainers? (ASSESS-AKI goal 5 X 1.0 mL) (1030) \_\_\_\_ aliquots

4a. If greater than 5 aliquots, estimate the volume of additional plasma saved. (1040) \_\_\_\_ mL  
(REPORT TO THE NEAREST ML. IF Q1030 = 5 AND NO ADDITIONAL PLASMA SAVED, RECORD 0 IN Q1040.)

5. How many packed cell pellets were produced from the 10 mL purple top vacutainers? (1 per tube, ASSESS-AKI goal 2) (1045) \_\_\_\_ pellets

6. How many 1.0 mL aliquots were produced from the 4.5 mL citrate blue top vacutainer? (ASSESS-AKI goal 2 X 1.0 mL) (1050) \_\_\_\_ aliquots

6a. If greater than 2 aliquots, estimate the volume of additional plasma saved. (1060) \_\_\_\_ mL  
(REPORT TO THE NEAREST ML. IF Q1050 = 2 AND NO ADDITIONAL PLASMA SAVED, RECORD 0 IN Q1060.)

7. Date samples frozen (1070) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

8. Time samples frozen (1080) \_\_\_\_  
(Aliquots should be stored in a -80 freezer)





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Serial Evaluation, and  
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ASSESS AKI  
ADULT  
OUTPATIENT V3M  
SPECIMEN PROCESSING  
2+

Participant ID: 1 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Participant Initials: \_\_\_\_  
Visit Number: 3 M  
Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Coordinator ID: \_\_\_\_

**Urine Specimen Processing**

9. Are there any urine samples to be processed? (1090) <sub>1</sub> Yes <sub>0</sub> No  
 → IF NO, COMPLETE SITE SPECIFIC WORKSHEET AND PROCEED TO BIOLOGICAL SAMPLE TRACKING MODULE.
10. How many 1.0 mL aliquots of urine were produced? (1100) \_\_\_\_ aliquots  
 (ASSESS-AKI goal 10 X 1.0 mL)
11. How many 10 mL aliquots of urine were produced? (1110) \_\_\_\_ aliquots  
 (ASSESS-AKI goal – 3 X 10 mL)
12. How many 10 mL aliquots of urine with protease inhibitors were produced? (1120) \_\_\_\_ aliquots  
 (ASSESS AKI goal – 1 X 10 mL)
13. Date samples frozen (1130) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 MM DD YYYY
14. Time samples frozen (1140) \_\_\_\_  
 (Aliquots should be stored in a -80 freezer)
- COMPLETE THE SITE SPECIFIC WORKSHEET AND IF THIS IS THE LAST COLLECTION ATTEMPT FOR THE VISIT, ENTER ALL APPROPRIATE SAMPLES INTO THE BIOLOGICAL SAMPLE TRACKING MODULE

Comments:

(6000) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





ASsessment,  
Serial Evaluation, and  
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NIH/NIDDK

ASSESS AKI  
PEDIATRIC  
ALERT

Participant ID: 2 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Date of Alert Value (s): (1000) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**Type of Alert Event(s):**

2. Was the alert due to Stage 2 hypertension (> 99<sup>th</sup> percentile plus 5 mmHg)? (1010) <sub>1</sub> Yes <sub>0</sub> No  
➔ REFER TO HEIGHT AND GENDER BASED BLOOD PRESSURE NORMS CHART.

3. Was the alert due to hypotension? (1020) <sub>1</sub> Yes <sub>0</sub> No  
➔ If YES:

3a. Systolic blood pressure < 60 for infants (1030) <sub>1</sub> Yes <sub>0</sub> No <sub>97</sub>  
N/A

3b. Systolic blood pressure < 70 for children older than one year. (1040) <sub>1</sub> Yes <sub>0</sub> No <sub>97</sub>  
N/A

4. Was the alert due to acute distress? (1050) <sub>1</sub> Yes <sub>0</sub> No  
➔ If YES:

4a. Chest pain (1060) <sub>1</sub> Yes <sub>0</sub> No

4b. Severe Respiratory Distress (1070) <sub>1</sub> Yes <sub>0</sub> No

4c. Acute Neurological Symptoms (1080) <sub>1</sub> Yes <sub>0</sub> No

4d. Other (1090) <sub>1</sub> Yes <sub>0</sub> No  
➔ If YES: SPECIFY \_\_\_\_\_

**Type of Alert Value(s):**

5. Was the alert due to laboratory results? (1100) <sub>1</sub> Yes <sub>0</sub> No  
➔ If YES:

5a. Creatinine doubling from last value (1140) <sub>1</sub> Yes <sub>0</sub> No

5b. Other abnormal lab value (1160) <sub>1</sub> Yes <sub>0</sub> No  
➔ If YES: SPECIFY \_\_\_\_\_

6. Was study site PI notified? (1170) <sub>1</sub> Yes <sub>0</sub> No







ASsessment,  
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NIH/NIDDK

ASSESS AKI  
PEDIATRIC  
MEDICAL  
EVENT  
QUESTIONNAIRE

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DO NOT ENTER. FOR REFERENCE PURPOSES ONLY.**

RECORD THE DATE OF THE PARTICIPANT'S LAST ASSESS AKI STUDY CONTACT.

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

1. Since your last ASSESS AKI study contact, have you/your child been hospitalized or gone to the emergency room for any medical problems? (1000) <sub>1</sub> Yes <sub>0</sub> No

➔ IF **NO**, PROCEED TO QUESTION 3.

➔ IF **YES**, RECORD THE NUMBER OF ER VISITS/HOSPITALIZATIONS FOR EACH EVENT

1a. Heart failure (heart not squeezing properly) or fluid in the lungs (pulmonary edema) (1010) <sub>1</sub> Yes <sub>0</sub> No

1ai. IF **YES**: Number of ER Visits/Hospitalizations (1020) \_\_\_\_\_

1b. Abnormal heart rhythm (1030) <sub>1</sub> Yes <sub>0</sub> No

1bi. IF **YES**: Number of ER Visits/Hospitalizations (1040) \_\_\_\_\_

1c. Stroke, mini-stroke (TIA) or brain attack, bleeding in the brain (hemorrhagic stroke, intracranial hemorrhage) (1050) <sub>1</sub> Yes <sub>0</sub> No

1ci. IF **YES**: Number of ER Visits/Hospitalizations (1060) \_\_\_\_\_

1d. Kidney transplant (1070) <sub>1</sub> Yes <sub>0</sub> No

1di. IF **YES**: Number of ER Visits/Hospitalizations (1080) \_\_\_\_\_

1e. Blockage in the arteries of your arms, legs or abdomen (peripheral vascular disease) (1090) <sub>1</sub> Yes <sub>0</sub> No

1ei. IF **YES**: Number of ER Visits/Hospitalizations (1100) \_\_\_\_\_

1f. Other medical condition(s) or problem(s) (1110) <sub>1</sub> Yes <sub>0</sub> No

1fi. IF **YES**: Number of ER Visits/Hospitalizations (1120) \_\_\_\_\_





ASsessment,  
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ASSESS AKI  
PEDIATRIC  
MEDICAL  
EVENT  
QUESTIONNAIRE

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

2. If any events are checked in Questions 1a – 1f, record the number of separate hospitalizations/ER visits since the last ASSESS AKI study contact. (1130) \_\_\_\_\_
- COMPLETE THE EVENT INFORMATION SHEET FOR EACH HOSPITALIZATION/ER VISIT
- COMPLETE THE HOSPITAL/ER RECORD EVALUATION (HOSP\_EVAL) FORM FOR EACH HOSPITALIZATION/ER VISIT EXCEPT WHEN DEATH OCCURS OUTSIDE OF THE HOSPITAL AND IS REPORTED BY PROXY
3. Since your last ASSESS AKI study contact, have you/your child had another heart surgery? (1140) <sub>1</sub> Yes <sub>0</sub> No
- IF **YES**, how many heart surgeries since the last ASSESS AKI study contact? (1150) \_\_\_\_\_
- Specify the types of surgery:
- 3a. Cavopulmonary connection (Glenn shunt or Hemi-Fontan) (1160) <sub>1</sub> Yes <sub>0</sub> No
- 3b. Fontan surgery (1170) <sub>1</sub> Yes <sub>0</sub> No
- 3c. Conduit replacement (1180) <sub>1</sub> Yes <sub>0</sub> No
- 3d. Mitral valve repair/replacement (1190) <sub>1</sub> Yes <sub>0</sub> No
- 3e. Aortic valve repair/replacement (1200) <sub>1</sub> Yes <sub>0</sub> No
- 3f. Other (1210) <sub>1</sub> Yes <sub>0</sub> No
- 3fi. IF **YES**: SPECIFY \_\_\_\_\_
4. Since your last ASSESS AKI study contact, have you/your child been admitted to the intensive care unit? (1220) <sub>1</sub> Yes <sub>0</sub> No
- IF **YES**:
- 4a. How many intensive care admissions since the last ASSESS AKI study contact? (1230) \_\_\_\_\_
- 4b. Did you/your child require mechanical ventilation (being on a ventilator)? (1240) <sub>1</sub> Yes <sub>0</sub> No
- 4c. Did you/your child have sepsis (severe infection)? (1250) <sub>1</sub> Yes <sub>0</sub> No
- 4d. Were you/your child in the intensive care unit for a repeat heart surgery? (1260) <sub>1</sub> Yes <sub>0</sub> No







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NIH/NIDDK

ASSESS AKI  
PEDIATRIC  
MEDICAL  
EVENT  
QUESTIONNAIRE

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

5. Since your last ASSESS AKI study contact, have you/your child had any of the following tests or procedures described below?

5a. Coronary angiography (cardiac catheterization, dye study of the heart) (1280) <sub>1</sub> Yes <sub>0</sub> No

→ IF **YES**: Indicate where angiography was performed (1290) <sub>1</sub> Inpatient  
<sub>2</sub> Outpatient  
<sub>3</sub> Both

6. If any tests or procedures are checked in Question 5a, record the number of separate test/procedures since the last ASSESS-AKI study contact. (1300) \_\_\_\_\_

- COMPLETE THE EVENT INFORMATION (EVENT\_INFO) SHEET
- IF INPATIENT, COMPLETE THE HOSPITAL/ER RECORD EVALUATION (HOSP\_EVAL) FORM FOR EACH TEST/PROCEDURE
- IF OUTPATIENT, COMPLETE THE OUTPATIENT VASCULAR PROCEDURE EVALUATION (OUTPT\_VASC) FORM

7. Since the last ASSESS AKI study contact, have you had any treatments described below?

7a. Hemodialysis or peritoneal dialysis (treatment with an artificial kidney) (1320) <sub>1</sub> Yes <sub>0</sub> No

→ IF **YES**: Indicate where dialysis was performed (1330) <sub>1</sub> Inpatient  
<sub>2</sub> Outpatient  
<sub>3</sub> Both

8. If any tests or procedures were completed in Question 7a, record the number of separate tests/procedures since the last ASSESS AKI study contact. (1340) \_\_\_\_\_

- COMPLETE THE EVENT INFORMATION (EVENT\_INFO) SHEET
- IF INPATIENT, COMPLETE THE HOSPITAL/ER RECORD EVALUATION (HOSP\_EVAL) FORM FOR EACH TEST/PROCEDURE
- IF OUTPATIENT, COMPLETE THE DIALYSIS EVALUATION (DIAL\_EVAL) FORM





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ASSESS AKI  
PEDIATRIC  
MEDICAL  
EVENT  
QUESTIONNAIRE

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

Research Coordinator Completed

Death (as reported by: \_\_\_\_\_)

(1350)



Record date deceased

(1360)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

→ If death reported, please complete the ASSESS AKI Withdrawal (WITHDR) form and Death Record Evaluation (DEATH\_EVAL) form.

**Comments**

(6000): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





ASsessment,  
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ASSESS AKI  
PEDIATRIC  
LIFESTYLE  
VISIT 3M

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DO NOT ENTER. FOR REFERENCE PURPOSES ONLY.**

RECORD THE DATE OF THE PARTICIPANT'S LAST ASSESS AKI STUDY VISIT.

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

1. Are you/your child currently in school or home-schooled?

(1000) <sub>1</sub> Yes <sub>0</sub> No

→ IF NO: Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1a. IF YES: What grade are you/your child in? (IF BETWEEN GRADES, ENTER LAST GRADE COMPLETED)

(1010) \_\_\_\_ \_\_\_\_

1b. IF YES: Are you/your child receiving any form of special education?

(1020) <sub>1</sub> Yes <sub>0</sub> No

→ IF YES: Please specify:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1c. IF YES: Did you/your child pass the last school year?

(1030) <sub>1</sub> Yes <sub>0</sub> No

→ IF THE PARTICIPANT IS LESS THAN 12 YEARS OF AGE, PROCEED TO QUESTION 29.

**Smoking History**

Since your/your child's last ASSESS AKI study visit:

2. Have you/your child smoked any cigarettes?

(1040) <sub>1</sub> Yes <sub>0</sub> No

→ IF NO, PROCEED TO QUESTION 8.

3. In the last 30 days, on how many days did you smoke cigarettes, even 1 or 2 puffs?

(1050) <sub>0</sub> 0 <sub>1</sub> 1 <sub>2</sub> >1

3a. IF >1: Indicate the number of days:

(1060) \_\_\_\_ \_\_\_\_





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ASSESS AKI  
PEDIATRIC  
LIFESTYLE  
VISIT 3M

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

4. Have you/your child smoked more than 100 cigarettes (approximately 5 packs)? (1070) <sub>1</sub> Yes <sub>0</sub> No
5. Do you/your child smoke cigarettes now? (1080) <sub>1</sub> Yes <sub>0</sub> No
6. How many cigarettes do you/your child or did you/your child usually smoke per day since you/your child's last ASSESS AKI study visit? (1090) \_\_\_\_ . \_\_\_\_ cigs/day
7. How many months did you/your child smoke this amount?  
ENTER 98 IF THE PARTICIPANT DOESN'T KNOW. (1100) \_\_\_\_ months
8. Have you/your child smoked cigars?  
➔ IF **NO**, PROCEED TO QUESTION 13. (1110) <sub>1</sub> Yes <sub>0</sub> No
9. Have you/your child smoked at least 20 cigars? (1120) <sub>1</sub> Yes <sub>0</sub> No
10. Do you/your child currently smoke cigars? (1130) <sub>1</sub> Yes <sub>0</sub> No
11. How many cigars do you/your child or did you/your child usually smoke per day since you/your child's last ASSESS AKI study visit? (1140) \_\_\_\_ . \_\_\_\_ cigars/day
12. How many months did you/your child smoke this amount?  
ENTER 98 IF THE PARTICIPANT DOESN'T KNOW. (1150) \_\_\_\_ months
13. Have you/your child ever smoked a tobacco pipe regularly for at least one year?  
(HERE "REGULARLY" MEANS AT LEAST TWO PIPEFULS OF TOBACCO A WEEK, ALMOST EVERY WEEK.)  
➔ IF **NO**, PROCEED TO QUESTION 20. (1160) <sub>1</sub> Yes <sub>0</sub> No
14. How old were you/your child when you started smoking a pipe regularly? (1170) \_\_\_\_ years old
15. Do you/your child still smoke a pipe regularly?  
➔ IF **NO**, PROCEED TO QUESTION 18. (1180) <sub>1</sub> Yes <sub>0</sub> No





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ASSESS AKI  
PEDIATRIC  
LIFESTYLE  
VISIT 3M

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

16. Altogether, how many years have you/your child smoked a pipe regularly? (1190) \_\_\_\_ . \_\_\_\_ years
17. How many pipefuls of tobacco do you/your child regularly smoke per day, on the average? (1200) \_\_\_\_ pipefuls  
(IF LESS THAN 1 PER DAY, RECORD 00)  
➔ PROCEED TO QUESTION 20.
18. How many years ago did you/your child stop? (1210) \_\_\_\_ . \_\_\_\_ years
19. How many pipefuls did you/your child usually smoke before you/your child stopped? (1220) \_\_\_\_ pipefuls  
(IF LESS THAN 1 PER DAY, RECORD 00)

**Alcohol Use History**

Since your/your child's last ASSESS AKI study visit:

20. Have you/your child had at least one alcoholic drink? (1230) <sub>1</sub> Yes <sub>0</sub> No  
➔ IF **NO**, PROCEED TO QUESTION 24.

**FOR QUESTIONS 21 THROUGH 23, AN ALCOHOLIC DRINK CAN BE:**



12 ounce can of beer OR



5 ounce glass of wine OR



1 shot of liquor

21. How often have you/your child had an alcoholic drink? (1240) <sub>1</sub> Every day  
CHOOSE ONLY ONE RESPONSE.  
➔ USE REFERENCE CARD A
- <sub>2</sub> 5 to 6 times a week
  - <sub>3</sub> 3 to 4 times a week
  - <sub>4</sub> 2 times a week
  - <sub>5</sub> 1 time a week
  - <sub>6</sub> 2 to 3 times a month
  - <sub>7</sub> 1 time a month
  - <sub>8</sub> 3 to 11 times since your last clinic visit
  - <sub>9</sub> 1 or 2 times since your last clinic visit
  - <sub>99</sub> Don't wish to answer





**12 ounce can of beer OR**



**5 ounce glass of wine OR**



**1 shot of liquor**

22. On the days you/your child drank, how many alcoholic drinks did you/your child usually have?

→ USE REFERENCE CARD B

(1250)

- <sub>1</sub> 25 or more drinks
- <sub>2</sub> 19 to 24 drinks
- <sub>3</sub> 16 to 18 drinks
- <sub>4</sub> 12 to 15 drinks
- <sub>5</sub> 9 to 11 drinks
- <sub>6</sub> 7 to 8 drinks
- <sub>7</sub> 5 to 6 drinks
- <sub>8</sub> 3 to 4 drinks
- <sub>9</sub> 2 drinks
- <sub>10</sub> 1 drink
- <sub>99</sub> Don't wish to answer

23. What was the largest number of alcoholic drinks that you/your child had in a 24-hour period?

→ USE REFERENCE CARD B

(1260)

- <sub>1</sub> 25 or more drinks
- <sub>2</sub> 19 to 24 drinks
- <sub>3</sub> 16 to 18 drinks
- <sub>4</sub> 12 to 15 drinks
- <sub>5</sub> 9 to 11 drinks
- <sub>6</sub> 7 to 8 drinks
- <sub>7</sub> 5 to 6 drinks
- <sub>8</sub> 3 to 4 drinks
- <sub>9</sub> 2 drinks
- <sub>10</sub> 1 drink
- <sub>99</sub> Don't wish to answer





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**Recreational Drug Use History**

Since your/your child's last ASSESS AKI study visit:

24. Have you/your child used marijuana? (1270) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer
- 24a. IF **YES**: Have you/your child used marijuana within the past 30 days? (1280) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer
25. Have you/your child used methamphetamines? (1290) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer
- 25a. IF **YES**: Have you/your child use them within the past 30 days? (1300) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer
26. Have you/your child used cocaine? (1310) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer
- 26a. IF **YES**: Have you/your child used cocaine within the past 30 days? (1320) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer





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27. Have you/your child used heroin? (1330) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

27a. IF **YES**: Have you/your child used heroin within the past 30 days? (1340) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

28. Have you/your child used other street drugs? SPECIFY: \_\_\_\_\_ (1350) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

28a. IF **YES**: Have you/your child used other street drugs within the past 30 days? (1360) <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>98</sub> Don't know  
<sub>99</sub> Don't wish to answer

**Health Insurance**

29. Since your/your child's last ASSESS AKI study visit, have any changes occurred in your/your child's healthcare coverage? (1370) <sub>1</sub> Yes <sub>0</sub> No  
 → IF **NO**, PROCEED TO QUESTION 34.







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30. (FOR US SITES ONLY) What type of healthcare coverage do you/your child have?  
PLEASE ANSWER YES OR NO TO EACH TYPE OF HEALTHCARE COVERAGE.

➔ USE REFERENCE CARD D

- 30a. Uninsured (1380) <sub>1</sub> Yes <sub>0</sub> No
- 30b. Self-insured (1390) <sub>1</sub> Yes <sub>0</sub> No
- 30c. COBRA (1400) <sub>1</sub> Yes <sub>0</sub> No
- 30d. Commercial/fee-for-service (1410) <sub>1</sub> Yes <sub>0</sub> No
- 30e. HMO (1420) <sub>1</sub> Yes <sub>0</sub> No
- 30f. Local/state insurance (1430) <sub>1</sub> Yes <sub>0</sub> No
- 30g. Military (1440) <sub>1</sub> Yes <sub>0</sub> No
- 30h. Medicare (1450) <sub>1</sub> Yes <sub>0</sub> No
- 30i. Medicaid (1460) <sub>1</sub> Yes <sub>0</sub> No
- 30j. Self-pay (1470) <sub>1</sub> Yes <sub>0</sub> No
- 30k. Other \_\_\_\_\_ (1480) <sub>1</sub> Yes <sub>0</sub> No

31. (FOR CANADIAN SITES ONLY) What type of healthcare coverage do you/your child have?  
PLEASE ANSWER YES OR NO TO EACH TYPE OF HEALTHCARE COVERAGE.

- 31a. Provincial/Public Health Insurance (1490) <sub>1</sub> Yes <sub>0</sub> No
- 31b. Private/Personal insurance (1500) <sub>1</sub> Yes <sub>0</sub> No





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32. Since your/your child's last ASSESS AKI study visit, was there ever a time when you were not covered by health insurance? (1510) <sub>1</sub> Yes <sub>0</sub> No
- IF YES: were you/your child not covered by health insurance for one month or more? (1520) <sub>1</sub> Yes <sub>0</sub> No
33. Since your/your child's last ASSESS AKI study visit, were you/your child denied health insurance? (1530) <sub>1</sub> Yes <sub>0</sub> No
34. Since your/your child's last ASSESS AKI study visit, were you/your child unable to fill a prescription because of the cost? (1540) <sub>1</sub> Yes <sub>0</sub> No
35. Since your/your child's last ASSESS AKI study visit, were you/your child unable to see your/your child's doctor because of the cost? (1550) <sub>1</sub> Yes <sub>0</sub> No

For Research Coordinator use only:

Where was the CRF completed? (1560) <sub>1</sub> At home  
<sub>2</sub> In-clinic  
<sub>3</sub> On the phone

Who completed the CRF? (1570) <sub>1</sub> Participant completed  
<sub>2</sub> Interviewer completed  
<sub>3</sub> Guardian completed

IF PARTICIPANT OR GUARDIAN COMPLETED: (1580) <sub>1</sub> Yes <sub>0</sub> No  
Did Research Coordinator review the CRF with the participant/guardian during the in-person visit?

IF YES: Signature of Research Coordinator (1590) \_\_\_\_\_

IF YES: Date Signature Completed (1600) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY





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**Comments:**

(6000): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





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**DO NOT ENTER. FOR REFERENCE PURPOSES ONLY.**

RECORD THE DATE OF THE PARTICIPANT'S LAST ASSESS AKI VISIT.

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

1. Since your last ASSESS AKI visit, were you/your child diagnosed or treated by a doctor or other health professional for cancer (excluding non-melanoma skin cancer)? (1000) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- ➔ IF NO, PROCEED TO QUESTION 2.
- 1a. Did you/your child receive chemotherapy? (1010) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- ➔ IF YES: Did you/your child receive?
- 1ai. cisplatin (1020) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 1aii. ifosfamide (1030) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 1aiii. methotrexate (1040) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 1av. carboplatin (1050) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
2. Since your last ASSESS AKI visit, were you/your child diagnosed or treated by a doctor or other health professional for any of the following conditions?
- 2a. Asthma or reactive airway disease (1060) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2b. Chronic obstructive pulmonary disease (cystic fibrosis, bronchiolitis) (1070) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2c. Hepatitis (B or C) infection (1080) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2d. Liver disease (1090) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2e. Genetic syndrome (1100) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2ei. If YES, Down's/Trisomy 21 (1110) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 2eii. If YES, DiGeorge/ 22q11 deletion (1120) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know





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2eiii. If **YES**, Turner syndrome (1130) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2eiv. If **YES**, Williams syndrome (1140) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2ev. If **YES**, VACTERL association (1150) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2evi. If **YES**, CHARGE syndrome (1160) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2evii. If **YES**, Undefined genetic syndrome (1170) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2eviii. If **YES**, Other (1180) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

➔ IF **YES**: SPECIFY \_\_\_\_\_

2f. Neurological/developmental disease (1190) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fi. If **YES**, Seizure disorder (1200) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fii. If **YES**, Hydrocephalus (1210) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fiii. If **YES**, Autism/autism spectrum disorder (1220) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fiv. If **YES**, ADD/ADHD (1230) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fv. If **YES**, Muscular dystrophy (1240) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fvi. If **YES**, Cerebral palsy (1250) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fvii. If **YES**, Spina bifida (1260) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fviii. If **YES**, Requires a wheelchair (1270) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2fvix. Other (1280) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

➔ IF **YES**: SPECIFY: \_\_\_\_\_

2g. Rheumatoid arthritis (1290) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2h. Gout (1300) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

2i. Systemic lupus (1310) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

➔ IF PARTICIPANT IS **MALE**, PROCEED TO QUESTION 7.



**Women's Health History**

Since your last ASSESS AKI visit:

3. Were you/your child pregnant in the time period? (1320) <sub>1</sub> Yes <sub>0</sub> No  
➔ IF **NO**, PROCEED TO QUESTION 4.

3a. Are you/your child currently pregnant? (1330) <sub>1</sub> Yes <sub>0</sub> No

AT V3M ONLY, QUESTION 4, 5, and 6 SHOULD BE ANSWERED BASED ON THE TIME PERIOD BEFORE ENROLLMENT IN THE STUDY AND THE V3M DATE.

4. Did you/your child begin menstruation? (1340) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know  
➔ IF **NO OR DON'T KNOW**, PROCEED TO QUESTION 7.

4a. IF **YES**: record the date. (1350) \_\_\_\_ month  
MM

(1355) \_\_\_\_ year  
YYYY

5. Have you/your child had any menstrual irregularities? (1360) <sub>1</sub> Yes <sub>0</sub> No

6. Do you/your child know when you/your child's last menstrual period started? (1370) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

6a. IF **YES**: What was the date? (1380) \_\_\_\_ month  
MM

(1382) \_\_\_\_ day  
DD

(1385) \_\_\_\_ year  
YYYY

**Renal History**

Since your last ASSESS AKI visit:

7. Did you/your child see a nephrologist/kidney doctor for your/your child's kidney problems? (1390) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

8. Did you/your child see any other doctor or health professional(s) (e.g. internist, family practitioner, hypertension specialist) for your kidney problems? (1400) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

➔ IF YOU ANSWERED **NO** TO BOTH QUESTIONS 7 AND 8, PROCEED TO QUESTION 15.





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9. Since your last ASSESS AKI visit, were you/your child diagnosed or treated by a doctor or other health professional for any of the following conditions?

- 9a. History of congenital kidney abnormalities (1410) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 9ai. Hydronephrosis (dilated kidney system) (1420) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 9aii. Vesico-ureteral reflux (reflux) (1430) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 9aiii. Single kidney (1440) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 9aiv. Horseshoe kidney (1450) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 9av. Small kidneys (1460) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 9avi. Dysplasia (1470) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 9avii. Polycystic kidney disease (1480) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 9aviii. Family history of kidney disease (1490) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

**The following questions address any healthcare you/your child have received since your last ASSESS AKI visit. Please provide a response for each item listed below.**

- 10. Was the level of protein in your/your child's urine measured? (1500) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 11. Was your/your child's kidney function measured by a 24-hour urine test or I-iothalamate clearance test? (1510) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 12. Did you/your child have a kidney xray (KUB)? (1520) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 13. Was your/your child's kidney function checked with a blood test? (1530) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 14. Have you/your child had any red, pink, or brown colored urine? (1540) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 15. Did you/your child have any vaccinations to lower your/your child's risk of infection? (1550) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know





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15a. IF **YES**: did you/your child have one or more vaccines to prevent bacterial infection? (e.g. pneumovax) (1560) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

15b. IF **YES**: did you/your child have a flu vaccine? (1570) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

15c. IF **YES**: did you/your child have the RSV vaccine? (1580) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

15ci. How many RSV vaccines? (1590) \_\_\_\_\_

**Hypertension History**

Since your last ASSESS AKI visit:

16. How long has it been since you/your child last had your/your child's blood pressure taken by a doctor or other health professional? (1600) \_\_\_\_\_

- IF PARTICIPANT DOES NOT KNOW, RECORD 98.
- (1610) <sub>1</sub> months  
<sub>2</sub> weeks  
<sub>3</sub> days  
<sub>97</sub> N/A

17. Did a doctor or other health professional tell you/your child for the first time that you/your child have hypertension or high blood pressure? (1620) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

17a. IF **YES**: do you/your child currently take prescribed medication for your/your child's hypertension or high blood pressure? (1630) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

**Diabetic History**

18. Have you/your child ever been told that you/your child have diabetes or high blood sugar? (1635) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

→ IF **NO**, PROCEED TO QUESTION 24.

19. Since your last ASSESS AKI visit, did a doctor or other health professional tell you/your child for the first time that you/your child have diabetes or high blood sugar? (1640) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

20. Are you/your child currently taking insulin? (1650) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know







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20a. Are you/your child currently taking injectable drugs, other than insulin, to manage your/your child's blood sugar? (1660) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

20b. Do you/your child currently take diabetes pills to lower your/your child's blood sugar? (These are sometimes called oral agents or oral hypoglycemic agents.) (1670) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

21. Since your last ASSESS AKI visit, did you/your child have your eyes examined by a doctor? (1680) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

➔ IF YES, record the examination date.

(1690) \_\_\_\_\_ month  
MM

(1695) \_\_\_\_\_ year  
YYYY

22. Since your last ASSESS AKI visit, did a doctor tell you/your child that diabetes has affected your eyes or that you have retinopathy? (1700) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

23. Do you/your child currently have any of these problems:

23a. Numbness or tingling in your/your child's hands or feet (other than falling asleep because you laid on your arm or leg) (1710) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

23b. Loss of sensation in your/your child's hands or feet (1720) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

23c. Decreased ability to feel the hotness or coldness of things you/your child touch (1730) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

23d. Sores or ulcers on your/your child's feet or ankles (1740) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

**Growth and Nutrition**

24. Since your last ASSESS AKI visit, did a doctor or other health professional tell you/your child that you/your child have a weight, height, or growth abnormality? (1750) <sub>1</sub> Yes <sub>0</sub> No

24a. If YES, Failure to thrive (1760) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know





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- 24b. If **YES**, Weight is too low for age and gender (1770) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 24c. If **YES**, Height is too low for age and gender (1780) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 24d. If **YES**, Both weight and height too low for age and gender (1790) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
25. Do you/your child have concerns about you/your child's growth? (1800) <sub>1</sub> Yes <sub>0</sub> No
26. Do you/your child receive nutrition through a nasogastric or gastrostomy tube? (1810) <sub>1</sub> Yes <sub>0</sub> No
27. Do you/your child have any nutritional restrictions for medical reasons? (1820) <sub>1</sub> Yes <sub>0</sub> No
- 27a. If **YES**, Celiac disease (1830) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 27b. If **YES**, Inflammatory bowel disease (1840) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know
- 27c. If **YES**, Other malabsorption problem (e.g., short bowel) (1850) <sub>1</sub> Yes <sub>0</sub> No <sub>98</sub> Don't know

For Research Coordinator use only:

Where was the CRF completed? (1860) <sub>1</sub> At home  
<sub>2</sub> In-clinic  
<sub>3</sub> On the phone

Who completed the CRF? (1870) <sub>1</sub> Participant completed  
<sub>2</sub> Interviewer completed  
<sub>3</sub> Guardian completed

**IF PARTICIPANT OR GUARDIAN COMPLETED:**  
Did Research Coordinator review the CRF with the participant/guardian during the in-person visit? (1880) <sub>1</sub> Yes <sub>0</sub> No

**IF YES:** Signature of Research Coordinator (1890) \_\_\_\_\_

**IF YES:** Date Signature Completed (1900) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC  
MEDICAL  
HISTORY

Participant ID: 2 - \_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Comments:**

(6000) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Have you/your child lived in your/your child's primary residence since birth? (1000) <sub>1</sub> Yes <sub>0</sub> No
- 1a. IF **NO**: How long have you/your child lived in the primary residence? (1010) \_\_\_\_ \_\_\_\_ years  
ESTIMATE IF UNCERTAIN. (1020) \_\_\_\_ \_\_\_\_ months
2. Which best describes the child's primary residence? CHECK ONE BOX ONLY. (1030)
- <sub>1</sub> A one-family house detached from any other house
  - <sub>2</sub> A one-family house attached to one or more houses
  - <sub>3</sub> A duplex
  - <sub>4</sub> A building for 3 or more families
  - <sub>5</sub> A mobile home or trailer
  - <sub>6</sub> Residential center (group home, nursing facility)
  - <sub>96</sub> Other (SPECIFY: \_\_\_\_\_)
3. Do you/your child have siblings? (1040) <sub>1</sub> Yes <sub>0</sub> No
- 3a. IF **YES**, how many siblings? (1050) \_\_\_\_ \_\_\_\_
- 3b. IF **YES**, how many siblings live in the same residence? (1060) \_\_\_\_ \_\_\_\_
4. How many parents/guardians live in your/your child's household? (1070) \_\_\_\_
5. What is your total annual gross household income? (1080)
- ➔ USE REFERENCE CARD A
- <sub>1</sub> \$20,000 or under
  - <sub>2</sub> \$20,001 – \$35,000
  - <sub>3</sub> \$35,001 – \$50,000
  - <sub>4</sub> \$50,001 – \$100,000
  - <sub>5</sub> More than \$100,000
  - <sub>99</sub> Don't wish to answer
6. How many legal guardians do you/your child have? (1090)
- ➔ IF **ZERO**, STOP.
- <sub>0</sub> Zero
  - <sub>1</sub> One
  - <sub>2</sub> Two





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Guardian 1**

7. What is the guardian's/your relationship to the child?

- (1100) <sub>1</sub> Mother  
<sub>2</sub> Father  
<sub>3</sub> Grandparent  
<sub>4</sub> Sibling  
<sub>5</sub> Aunt/Uncle  
<sub>6</sub> Legal guardian  
<sub>7</sub> Friend  
<sub>96</sub> Other (SPECIFY \_\_\_\_\_)

8. What is the guardian's/your current marital status?

- (1110) <sub>1</sub> Never married  
<sub>2</sub> Currently married  
<sub>3</sub> Domestic partner  
<sub>4</sub> Separated  
<sub>5</sub> Divorced  
<sub>6</sub> Widowed  
<sub>99</sub> Don't wish to answer

9. What is the highest level of education that the guardian/you have completed?

➔ USE REFERENCE CARD B

- (1120) <sub>1</sub> Less than 7<sup>th</sup> grade or no formal education  
<sub>2</sub> 7<sup>th</sup> to 12<sup>th</sup> grade, no high school diploma  
<sub>3</sub> High school graduate or equivalent (e.g. GED)  
<sub>4</sub> Technical or vocational school degree  
<sub>5</sub> Some college education, but no completed degree  
<sub>6</sub> College graduate  
<sub>7</sub> Professional or graduate degree (e.g. Master's, PhD, JD, MD)  
<sub>99</sub> Don't wish to answer





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

10. What is the guardian's/your current primary employment status?  
→ IF ON TEMPORARY MEDICAL LEAVE, PROCEED TO QUESTION 11.

→ IF STUDENT, NEVER WORKED, OR DON'T WISH TO ANSWER, PROCEED TO QUESTION 12 OR STOP IF THERE IS ONLY 1 GUARDIAN.

→ USE REFERENCE CARD C

- (1130) <sub>1</sub> Employed part-time  
<sub>2</sub> Employed full-time  
<sub>3</sub> Student  
<sub>4</sub> Temporarily laid off/on strike  
<sub>5</sub> On temporary medical leave  
<sub>6</sub> Permanently disabled  
<sub>7</sub> Retired, not currently working  
<sub>8</sub> Full-time home maker  
<sub>9</sub> Unemployed  
<sub>10</sub> Never worked  
<sub>99</sub> Don't wish to answer

10a. If **NOT** currently employed, when was the last time the guardian/you were employed?  
RESPONSE SHOULD BE WRITTEN AS DATE MM/YYYY.

(1140) \_\_\_\_ month  
MM

(1150) \_\_\_\_ year  
YYYY

→ IF PARTICIPANT CANNOT REMEMBER THE MONTH OR YEAR RECORD 98 FOR MONTH AND/OR 9898 FOR YEAR





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

11. What type of work does/did the guardian/you primarily do?  
→ USE REFERENCE CARD D

- (1160) <sub>1</sub> Professional, executive occupation, business owner
- <sub>2</sub> Manager, technical occupation
- <sub>3</sub> Clerical, sales, administrative support occupation, technician
- <sub>4</sub> Skilled labor (e.g. certified electrician, carpenter, welder)
- <sub>5</sub> Semi-skilled labor (e.g. construction help, mechanic's help)
- <sub>6</sub> Other labor (e.g. porters, bell hops, manual labor)
- <sub>7</sub> Home maker
- <sub>96</sub> Other (SPECIFY WORK: \_\_\_\_\_)
- <sub>99</sub> Don't wish to answer





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Guardian 2**

12. What is the guardian's/your relationship to the child?

- (1170) <sub>1</sub> Mother  
<sub>2</sub> Father  
<sub>3</sub> Grandparent  
<sub>4</sub> Sibling  
<sub>5</sub> Aunt/Uncle  
<sub>6</sub> Legal guardian  
<sub>7</sub> Friend  
<sub>96</sub> Other (SPECIFY \_\_\_\_\_)

13. What is the guardian's/your current marital status?

- (1180) <sub>1</sub> Never married  
<sub>2</sub> Currently married  
<sub>3</sub> Domestic partner  
<sub>4</sub> Separated  
<sub>5</sub> Divorced  
<sub>6</sub> Widowed  
<sub>99</sub> Don't wish to answer

14. What is the highest level of education that the guardian/you have completed?

→ USE REFERENCE CARD B

- (1190) <sub>1</sub> Less than 7<sup>th</sup> grade or no formal education  
<sub>2</sub> 7<sup>th</sup> to 12<sup>th</sup> grade, no high school diploma  
<sub>3</sub> High school graduate or equivalent (e.g. GED)  
<sub>4</sub> Technical or vocational school degree  
<sub>5</sub> Some college education, but no completed degree  
<sub>6</sub> College graduate  
<sub>7</sub> Professional or graduate degree (e.g. Master's, PhD, JD, MD)  
<sub>99</sub> Don't wish to answer







ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

15. What is the guardian's/your current primary employment status?

→ IF ON TEMPORARY MEDICAL LEAVE, PROCEED TO QUESTION 16.

→ IF STUDENT, NEVER WORKED, OR DON'T WISH TO ANSWER, STOP.

→ USE REFERENCE CARD C

- (1200) <sub>1</sub> Employed part-time
- <sub>2</sub> Employed full-time
- <sub>3</sub> Student
- <sub>4</sub> Temporarily laid off/on strike
- <sub>5</sub> On temporary medical leave
- <sub>6</sub> Permanently disabled
- <sub>7</sub> Retired, not currently working
- <sub>8</sub> Full-time home maker
- <sub>9</sub> Unemployed
- <sub>10</sub> Never worked
- <sub>99</sub> Don't wish to answer

15a. If **NOT** currently employed, when was the last time the guardian/you were employed?  
RESPONSE SHOULD BE WRITTEN AS DATE MM/YYYY.

(1210) \_\_\_\_ month  
MM

(1220) \_\_\_\_ year  
YYYY

→ IF PARTICIPANT CANNOT REMEMBER THE MONTH OR YEAR RECORD 98 FOR MONTH AND/OR 9898 FOR YEAR





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

16. What type of work does/did the guardian/you primarily do?  
→ USE REFERENCE CARD D

- (1230)
- <sub>1</sub> Professional, executive occupation, business owner
  - <sub>2</sub> Manager, technical occupation
  - <sub>3</sub> Clerical, sales, administrative support occupation, technician
  - <sub>4</sub> Skilled labor (e.g. certified electrician, carpenter, welder)
  - <sub>5</sub> Semi-skilled labor (e.g. construction help, mechanic's help)
  - <sub>6</sub> Other labor (e.g. porters, bell hops, manual labor)
  - <sub>7</sub> Home maker
  - <sub>96</sub> Other (SPECIFY WORK: \_\_\_\_\_)
  - <sub>99</sub> Don't wish to answer





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC OUTPATIENT  
DEMOGRAPHIC  
INFORMATION

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

For Research Coordinator use only:

Where was the CRF completed?

- (1240) <sub>1</sub> At home  
<sub>2</sub> In-clinic  
<sub>3</sub> On the phone

For Research Coordinator use only: CRF was:

- (1250) <sub>1</sub> Participant completed  
<sub>2</sub> Interviewer completed  
<sub>3</sub> Guardian completed

**IF PARTICIPANT OR GUARDIAN COMPLETED:**  
Did Research Coordinator review the CRF with the  
participant/guardian during the in-person visit?

- (1260) <sub>1</sub> Yes <sub>0</sub> No

IF **YES**: Signature of Research Coordinator

(1270) \_\_\_\_\_

IF **YES**: Date Signature Completed

(1280) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**Comments:**

(6000): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





Assessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC  
OUTPATIENT V3M  
SPECIMEN COLLECTION:  
BLOOD

Participant ID: 2 - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Coordinator ID: \_\_\_\_\_

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) <sub>1</sub> Yes <sub>0</sub> No

**Blood Specimen Collection**

RECORD ALL TIMES USING A 24-HOUR CLOCK.

2. Date of blood collection: (1010) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY
3. Time of blood collection: (1020) \_\_\_\_\_
4. Was a blood sample collected? (1030) <sub>1</sub> Yes <sub>0</sub> No

➔ **IF NO**, RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THIS COLLECTION AND COMPLETE THE PEDIATRIC OUTPATIENT V3M SPECIMEN 2+ COLLECTION: BLOOD (P2\_V3M\_COLLECT\_BLD\_2) FORM.

➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER V3M WITHIN THE VISIT WINDOW.

➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT 3M CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE.

5. (COMPLETE ONLY IF BLOOD WAS COLLECTED) How was blood collected? (1040) <sub>1</sub> Venipuncture <sub>2</sub> Capillary

6. Was the following vacutainer collected?

Priority Order	Specimen type	
1	EDTA (purple)/Capillary	(1050) <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No

➔ **IF NO**, COMPLETE THE SITE SPECIFIC WORKSHEET.

Comments:

(6000) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





Assessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC  
OUTPATIENT V3M  
SPECIMEN COLLECTION:  
URINE

Participant ID: 2 - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Coordinator ID: \_\_\_\_\_

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) <sub>1</sub> Yes <sub>0</sub> No

**Urine Specimen Collection**

RECORD ALL TIMES USING A 24-HOUR CLOCK.

2. Date of urine collection: (1020) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY
3. Time of urine collection: (1030) \_\_\_\_\_
4. Is the participant wearing a diaper? (1035) <sub>1</sub> Yes <sub>0</sub> No
5. How was the urine sample collected? (1040) <sub>1</sub> Midstream  
<sub>2</sub> Cotton ball  
<sub>3</sub> Bag

6. Was the minimum amount of urine collected? (1050) <sub>1</sub> Yes <sub>0</sub> No  
DIAPER WEARERS SHOULD PROVIDE 1.6 ML  
NON-DIAPER WEARERS SHOULD PROVIDE 5 ML.

- ➔ **IF NO**, RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THIS COLLECTION AND COMPLETE THE PEDIATRIC OUTPATIENT V3M SPECIMEN 2+ COLLECTION:URINE (P2\_V3M\_COLLECT\_UA\_2) FORM.
- ➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER V3M WITHIN THE VISIT WINDOW.
- ➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT 3M CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE AND COMPLETE THE ASSESS-AKI WITHDRAWAL (WITHDR) FORM

Comments:

(6000) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





Assessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PEDIATRIC  
OUTPATIENT V3M  
SPECIMEN PROCESSING

Participant ID: 2 - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Blood Specimen Processing**

1. Are there any blood samples to be processed? (1000) <sub>1</sub> Yes <sub>0</sub> No  
 → IF **NO**, COMPLETE THE SITE SPECIFIC WORKSHEET AND PROCEED TO QUESTION 7.
2. How many 0.5 mL aliquots were produced? (1010) \_\_\_\_ aliquots  
 (ASSESS-AKI goal 1 X 0.5 mL)
3. How many 0.25 mL aliquots were produced? (1020) \_\_\_\_ aliquots  
 (ASSESS-AKI goal 4 X 0.25 mL)
4. Is there an extra aliquot? (1040) <sub>1</sub> Yes <sub>0</sub> No  
 4a. If YES, estimate volume of additional plasma saved. (1050) \_\_\_\_ . \_\_\_\_ mL
5. Date samples frozen (1060) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 MM DD YYYY
6. Time samples frozen (1070) \_\_\_\_\_  
 RECORD TIME USING A 24-HOUR CLOCK.  
 (Aliquots should be stored in a -80 freezer)

**Urine Specimen Processing**

7. Are there any urine samples to be processed? (1080) <sub>1</sub> Yes <sub>0</sub> No  
 → IF **NO**, COMPLETE THE SITE SPECIFIC WORKSHEET AND PROCEED TO BIOLOGICAL SAMPLE TRACKING MODULE.
8. How many 1.0 mL aliquots of urine were produced? (1090) \_\_\_\_ aliquots  
 (ASSESS-AKI goal – 10 X 1.0 mL)
9. (COMPLETE ONLY IF DIAPER-WEARER) Is there an extra aliquot of less than 1.0 mL? (1095) <sub>1</sub> Yes <sub>0</sub> No
10. How many 10 mL aliquots of urine were produced? (1100) \_\_\_\_ aliquots  
 (ASSESS-AKI goal – 1 X 10 mL)
11. Is there an extra aliquot of less than 10 mL? (1110) <sub>1</sub> Yes <sub>0</sub> No
12. Date samples frozen (1120) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 MM DD YYYY
13. Time samples frozen (1130) \_\_\_\_\_  
 RECORD TIME USING A 24-HOUR CLOCK.  
 (Aliquots should be stored in a -80 freezer)





ASsessment,  
 Serial Evaluation, and  
 Subsequent Sequelae in AKI  
 NIH/NIDDK

ASSESS AKI  
 PEDIATRIC  
 OUTPATIENT V3M  
 SPECIMEN PROCESSING

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: 3 M

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

Comments:

(6000) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PedsQL™  
CHILD REPORT  
(Ages 8-12)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DIRECTIONS**

Below is a list of things that might be a problem for you. Please tell us **how much of a problem** each one has been for you during the **past ONE month** by checking the box for:

- 0 if it is **never** a problem
- 1 if it is **almost never** a problem
- 2 if it is **sometimes** a problem
- 3 if it is **often** a problem
- 4 if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has this been for you ...

**About my Health and Activities (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
1. It is hard for me to walk more than one block	(1000)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
2. It is hard for me to run	(1010)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
3. It is hard for me to do sports activity or exercise	(1020)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
4. It is hard for me to lift something heavy	(1030)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
5. It is hard for me to take a bath or shower by myself	(1040)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
6. It is hard for me to do chores around the house	(1050)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>







ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PedsQL™  
CHILD REPORT  
(Ages 8-12)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**About my Health and Activities (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
7. I hurt or ache	(1060)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
8. I have low energy	(1070)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**About my Feelings (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
9. I feel afraid or scared	(1080)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
10. I feel sad or blue	(1090)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
11. I feel angry	(1100)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
12. I have trouble sleeping	(1110)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
13. I worry about what will happen to me	(1120)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**How I Get Along with Others (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
14. I have trouble getting along with other kids	(1130)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
15. Other kids do not want to be my friend	(1140)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





ASsessment,  
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ASSESS AKI  
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CHILD REPORT  
(Ages 8-12)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**How I Get Along with Others (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
16. Other kids tease me	(1150)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
17. I cannot do things that other kids my age can do	(1160)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
18. It is hard to keep up when I play with other kids	(1170)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**About School (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
19. It is hard to pay attention in class	(1180)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
20. I forget things	(1190)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
21. I have trouble keeping up with my schoolwork	(1200)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
22. I miss school because of not feeling well	(1210)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
23. I miss school to go to the doctor or hospital	(1220)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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NIH/NIDDK

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PARENT REPORT for  
TEENS  
(Ages 13-<18)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DIRECTIONS**

Below is a list of things that might be a problem for **your teen**. Please tell us **how much of a problem** each one has been for **your teen** during the **past ONE month** by checking the box for:

- 0 if it is **never** a problem
- 1 if it is **almost never** a problem
- 2 if it is **sometimes** a problem
- 3 if it is **often** a problem
- 4 if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has this been for you ...

**Physical Functioning (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
1. Walking more than one block	(1000)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
2. Running	(1010)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
3. Participating in sports activity or exercise	(1020)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
4. Lifting something heavy	(1030)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
5. Taking a bath or shower by him or herself	(1040)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
6. Doing chores around the house	(1050)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
7. Having hurts or aches	(1060)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
8. Low energy level	(1070)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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TEENS  
(Ages 13-<18)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Emotional Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
9. Feeling afraid or scared	(1080)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
10. Feeling sad or blue	(1090)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
11. Feeling angry	(1100)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
12. Trouble sleeping	(1110)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
13. Worrying about what will happen to him or her	(1120)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**Social Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
14. Getting along with other teens	(1130)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
15. Other teens not wanting to be his or her friend	(1140)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
16. Getting teased by other teens	(1150)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
17. Not able to do things that other teens his or her age can do	(1160)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
18. Keeping up with other teens	(1170)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**School Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
19. Paying attention in class	(1180)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
20. Forgetting things	(1190)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
21. Keeping up with schoolwork	(1200)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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TEENS  
(Ages 13-<18)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**School Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
22. Missing school because of not feeling well	(1210)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
23. Missing school to go to the doctor or hospital	(1220)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>



**DIRECTIONS**

Below is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by checking the box for:

- 0 if it is **never** a problem
- 1 if it is **almost never** a problem
- 2 if it is **sometimes** a problem
- 3 if it is **often** a problem
- 4 if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has your child had with ...

**Physical Functioning (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
1. Walking	(1000)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
2. Running	(1010)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
3. Participating in active play or exercise	(1020)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
4. Lifting something heavy	(1030)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
5. Bathing	(1040)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
6. Helping to pick up his or her toys	(1050)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
7. Having hurts or aches	(1060)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
8. Low energy level	(1070)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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(Ages 2-4)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Emotional Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
9. Feeling afraid or scared	(1080)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
10. Feeling sad or blue	(1090)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
11. Feeling angry	(1100)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
12. Trouble sleeping	(1110)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
13. Worrying	(1120)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**Social Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
14. Playing with other children	(1130)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
15. Other kids not wanting to play with him or her	(1140)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
16. Getting teased by other children	(1150)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
17. Not able to do things that other children his or her age can do	(1160)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
18. Keeping up when playing with other children	(1170)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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PARENT REPORT for  
YOUNG CHILDREN  
(Ages 2-4)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**\*Please complete this section if your child attends school or daycare**

**School Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
19. Doing the same school activities as peers	(1180)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
20. Missing school/daycare because of not feeling well	(1190)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
21. Missing school/daycare to go to the doctor or hospital	(1200)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>







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PARENT REPORT for  
YOUNG CHILDREN  
(Ages 5-7)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DIRECTIONS**

Below is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by checking the box for:

- 0 if it is **never** a problem
- 1 if it is **almost never** a problem
- 2 if it is **sometimes** a problem
- 3 if it is **often** a problem
- 4 if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has your child had with ...

**Physical Functioning (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
1. Walking more than one block	(1000)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
2. Running	(1010)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
3. Participating in sports activity or exercise	(1020)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
4. Lifting something heavy	(1030)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
5. Taking a bath or shower by him or herself	(1040)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
6. Doing chores, like picking up his or her toys	(1050)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
7. Having hurts or aches	(1060)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
8. Low energy level	(1070)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Emotional Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
9. Feeling afraid or scared	(1080)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
10. Feeling sad or blue	(1090)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
11. Feeling angry	(1100)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
12. Trouble sleeping	(1110)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
13. Worrying about what will happen to him or her	(1120)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**Social Functioning (problems with...)**

14. Getting along with other children	(1130)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
15. Other kids not wanting to be his or her friend	(1140)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
16. Getting teased by other children	(1150)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
17. Not able to do things that other children his or her age can do	(1160)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
18. Keeping up when playing with other children	(1170)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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(Ages 5-7)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**School Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
19. Paying attention in class	(1180)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
20. Forgetting things	(1190)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
21. Keeping up with school activities	(1200)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
22. Missing school because of not feeling well	(1210)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
23. Missing school to go to the doctor or hospital	(1220)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DIRECTIONS**

Below is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by checking the box for:

- 0 if it is **never** a problem
- 1 if it is **almost never** a problem
- 2 if it is **sometimes** a problem
- 3 if it is **often** a problem
- 4 if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has your child had with ...

**Physical Functioning (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
1. Walking more than one block	(1000)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
2. Running	(1010)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
3. Participating in sports activity or exercise	(1020)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
4. Lifting something heavy	(1030)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
5. Taking a bath or shower by him or herself	(1040)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
6. Doing chores around the house	(1050)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
7. Having hurts or aches	(1060)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
8. Low energy level	(1070)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

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Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**Emotional Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
9. Feeling afraid or scared	(1080)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
10. Feeling sad or blue	(1090)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
11. Feeling angry	(1100)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
12. Trouble sleeping	(1110)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
13. Worrying about what will happen to him or her	(1120)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**Social Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
14. Getting along with other children	(1130)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
15. Other kids not wanting to be his or her friend	(1140)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
16. Getting teased by other children	(1150)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
17. Not able to do things that other children his or her age can do	(1160)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
18. Keeping up with other children	(1170)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**School Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
19. Paying attention in class	(1180)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
20. Forgetting things	(1190)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
21. Keeping up with schoolwork	(1200)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**School Functioning (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
22.	Missing school because of not feeling well (1210)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
23.	Missing school to go to the doctor or hospital (1220)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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(Ages 13-<18)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DIRECTIONS**

Below is a list of things that might be a problem for you. Please tell us **how much of a problem** each one has been for you during the **past ONE month** by checking the box for:

- 0 if it is **never** a problem
- 1 if it is **almost never** a problem
- 2 if it is **sometimes** a problem
- 3 if it is **often** a problem
- 4 if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has this been for you ...

**About my Health and Activities (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
1. It is hard for me to walk more than one block	(1000)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
2. It is hard for me to run	(1010)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
3. It is hard for me to do sports activity or exercise	(1020)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
4. It is hard for me to lift something heavy	(1030)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
5. It is hard for me to take a bath or shower by myself	(1040)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
6. It is hard for me to do chores around the house	(1050)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**About my Health and Activities (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
7. I hurt or ache	(1060)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
8. I have low energy	(1070)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**About my Feelings (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
9. I feel afraid or scared	(1080)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
10. I feel sad or blue	(1090)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
11. I feel angry	(1100)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
12. I have trouble sleeping	(1110)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
13. I worry about what will happen to me	(1120)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**How I Get Along with Others (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
14. I have trouble getting along with other teens	(1130)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
15. Other teens do not want to be my friend	(1140)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>







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Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**How I Get Along with Others (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
16. Other teens tease me	(1150)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
17. I cannot do things that other teens my age can do	(1160)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
18. It is hard to keep up with my peers	(1170)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**About School (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
19. It is hard to pay attention in class	(1180)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
20. I forget things	(1190)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
21. I have trouble keeping up with my schoolwork	(1200)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
22. I miss school because of not feeling well	(1210)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
23. I miss school to go to the doctor or hospital	(1220)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**DIRECTIONS**

Below is a list of things that might be a problem for you. Please tell us **how much of a problem** each one has been for you during the **past ONE month** by checking the box for:

- 0 if it is **never** a problem
- 1 if it is **almost never** a problem
- 2 if it is **sometimes** a problem
- 3 if it is **often** a problem
- 4 if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has this been for you ...

**About my Health and Activities (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
1. It is hard for me to walk more than one block	(1000)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
2. It is hard for me to run	(1010)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
3. It is hard for me to do sports activity or exercise	(1020)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
4. It is hard for me to lift something heavy	(1030)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
5. It is hard for me to take a bath or shower by myself	(1040)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
6. It is hard for me to do chores around the house	(1050)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





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Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**About my Health and Activities (problems with ...)**

		Never	Almost never	Sometimes	Often	Almost always
7. I hurt or feel pain	(1060)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
8. I have low energy	(1070)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**About my Feelings (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
9. I feel afraid or scared	(1080)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
10. I feel sad or blue	(1090)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
11. I feel angry	(1100)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
12. I have trouble sleeping	(1110)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
13. I worry about what will happen to me	(1120)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**How I Get Along with Others (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
14. I have trouble getting along with other young adults	(1130)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
15. Other young adults do not want to be my friend	(1140)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PedsQL™  
YOUNG ADULT REPORT  
(Ages 18-25)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**How I Get Along with Others (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
16. Other young adults tease me	(1150)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
17. I cannot do things that others my age can do	(1160)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
18. It is hard to keep up with my peers	(1170)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**About my Work/Studies (problems with...)**

		Never	Almost never	Sometimes	Often	Almost always
19. It is hard to pay attention at work or school	(1180)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
20. I forget things	(1190)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
21. I have trouble keeping up with my work or studies	(1200)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
22. I miss work or school because of not feeling well	(1210)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
23. I miss work or school to go to the doctor or hospital	(1220)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PedsQL™  
YOUNG CHILD REPORT  
(Ages 5-7)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**INSTRUCTIONS FOR INTERVIEWER**

I am going to ask you some questions about things that might be a problem for some children. I want to know how much of a problem any of these things might be for you.

SHOW THE CHILD THE TEMPLATE AND POINT TO THE RESPONSES AS YOU READ.

If it is not at all a problem for you, point to the smiling face  
If it is sometimes a problem for you, point to the middle face  
If it is a problem for you a lot, point to the frowning face

I will read each question. Point to the pictures to show me how much of a problem it is for you.  
Let's try a practice one first.

	Not at All	Sometimes	A lot
Is it hard for you to snap your fingers			

ASK THE CHILD TO DEMONSTRATE SNAPPING HIS OR HER FINGERS TO DETERMINE WHETHER OR NOT THE QUESTION WAS ANSWERED CORRECTLY. REPEAT THE QUESTION IF THE CHILD DEMONSTRATES A RESPONSE THAT IS DIFFERENT FROM HIS OR HER ACTION.

Think about how you have been doing for the last few weeks. Please listen carefully to each sentence and tell me how much of a problem this is for you.

AFTER READING THE ITEM, GESTURE TO THE TEMPLATE. IF THE CHILD HESITATES OR DOES NOT SEEM TO UNDERSTAND HOW TO ANSWER, READ THE RESPONSE OPTIONS WHILE POINTING AT THE FACES.





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YOUNG CHILD REPORT  
(Ages 5-7)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

		Not at all	Sometimes	A lot
1.	It is hard for you to walk. (1000)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
2.	It is hard for you to run. (1010)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
3.	It is hard for you to play sports or exercise. (1020)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
4.	It is hard for you to pick up big things. (1030)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
5.	It is hard for you to take a bath or shower. (1040)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
6.	It is hard for you to do chores (like pick up your toys). (1050)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
7.	Do you have hurts or aches? (Where? _____ ) (1060)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
8.	Do you ever feel too tired to play? (1070)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>





ASsessment,  
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NIH/NIDDK

ASSESS AKI  
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YOUNG CHILD REPORT  
(Ages 5-7)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

Remember, tell me how much of a problem this has been for you for the last few weeks.

**Social Functioning (problems with...)**

		Not at all	Sometimes	A lot
9. Do you feel scared?	(1080)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
10. Do you feel sad?	(1090)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
11. Do you feel mad?	(1100)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
12. Do you have trouble sleeping?	(1110)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
13. Do you worry about what will happen to you?	(1120)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>

**Social Functioning (problems with...)**

		Not at all	Sometimes	A lot
14. Is it hard for you to get along with other kids?	(1130)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
15. Do other kids say they do not want to play with you?	(1140)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
16. Do other kids tease you?	(1150)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
17. Can other kids do things that you cannot do?	(1160)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
18. Is it hard for you to keep up when you play with other kids?	(1170)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>





ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

ASSESS AKI  
PedsQL™  
YOUNG CHILD REPORT  
(Ages 5-7)

Participant ID: 2 - \_\_\_\_ - \_\_\_\_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

**School Functioning (problems with...)**

		Not at all	Sometimes	A lot
19.	Is it hard for you to pay attention in school? (1180)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
20.	Do you forget things? (1190)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
21.	Is it hard to keep up with schoolwork? (1200)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
22.	Do you miss school because of not feeling good? (1210)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>
23.	Do you miss school because you have to go to the doctor's or hospital? (1220)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>4</sub>







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# Your Health and Well-Being

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**This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Thank you for completing this survey!**

**For each of the following questions, please mark an  in the one box that best describes your answer.**

**1. In general, would you say your health is:**

Excellent	Very good	Good	Fair	Poor
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited at all
	▼	▼	▼
a. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.....	<input type="checkbox"/> 1.....	<input type="checkbox"/> 2.....	<input type="checkbox"/> 3
b. Climbing <u>several</u> flights of stairs .....	<input type="checkbox"/> 1.....	<input type="checkbox"/> 2.....	<input type="checkbox"/> 3

**3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	▼	▼	▼	▼	▼

a. Accomplished less than you would like .....  1 .....  2 .....  3 .....  4 .....  5

b. Were limited in the kind of work or other activities .....  1 .....  2 .....  3 .....  4 .....  5

**4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	▼	▼	▼	▼	▼

a. Accomplished less than you would like .....  1 .....  2 .....  3 .....  4 .....  5

b. Did work or other activities less carefully than usual .....  1 .....  2 .....  3 .....  4 .....  5

**5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?**

Not at all	A little bit	Moderately	Quite a bit	Extremely
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	▼	▼	▼	▼	▼
a. Have you felt calm and peaceful?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. Did you have a lot of energy? .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Have you felt downhearted and depressed?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

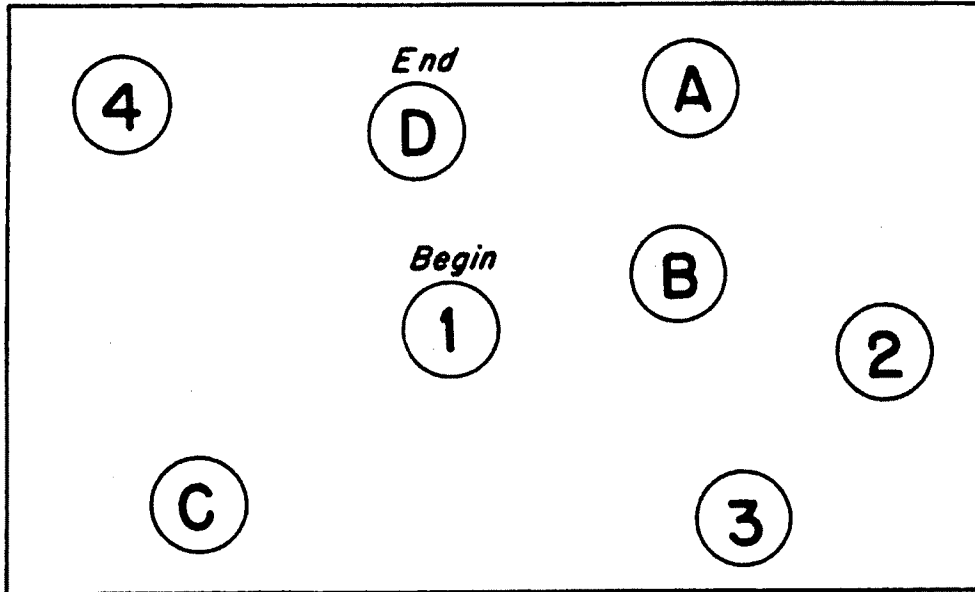
All of the time	Most of the time	Some of the time	A little of the time	None of the time
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

*Thank you for completing these questions!*

# TRAIL MAKING

## Part B

SAMPLE



*End*

13

10

8

9

I

D

B

4

3

7

*Begin*

1

5

H

C

12

G

A

J

2

6

L

E

F

K

11



ASsessment,  
 Serial Evaluation, and  
 Subsequent Sequelae in AKI  
 NIH/NIDDK

ASSESS AKI  
 TRAILS  
 B  
 SCORING

Participant ID: 1 - \_\_\_\_ - \_\_\_\_

Participant Initials: \_\_\_\_

Visit Number: \_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Coordinator ID: \_\_\_\_

1. How many years of school has the participant completed? (1000) \_\_\_\_ years  
 (GED=12 YEARS)
  
2. Number of seconds required to complete the task (1010) \_\_\_\_ seconds  
 (IF THE PARTICIPANT HAS NOT COMPLETED THE TASK AFTER 5 MINUTES, STOP THE TASK AND ENTER 999 FOR THIS FIELD)

Comments:

(6000) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





ASsessment,  
 Serial Evaluation, and  
 Subsequent Sequelae in AKI  
 NIH/NIDDK

ASSESS AKI  
 UNITED STATES  
 LABORATORY  
 RESULTS  
 CBC

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

COMPLETE FOR ADULT PARTICIPANTS ONLY.

1. Date of blood draw: (1000) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 MM DD YYYY

2. CBC Results (based on local laboratory results):

2a. WBC:	(1010)	____ . ____ thousand/uL
2b. Platelets:	(1020)	____ thousand/uL
2c. Hemoglobin:	(1030)	____ . ____ g/dL
2d. Hematocrit:	(1040)	____ . ____ %

3. Renal function (VISIT 3M ONLY)

3a. Creatinine	(1050)	____ . ____ mg/dL
----------------	--------	-------------------

**Comments:**

(6000) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_







ASsessment,  
Serial Evaluation, and  
Subsequent Sequelae in AKI  
NIH/NIDDK

## ASSESS AKI WITHDRAWAL

Participant ID: \_\_ - \_\_ - \_\_ - \_\_ - \_\_

Participant Initials: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Visit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Coordinator ID: \_\_\_\_\_

1. Did the participant complete the study?

(1000) <sub>1</sub> Yes <sub>0</sub> No

1a. IF **NO**: INDICATE **PRIMARY** REASON FOR  
WITHDRAWAL:

- (1010) <sub>1</sub> Ineligible due to inpatient blood collection
- <sub>2</sub> Ineligible due to inpatient urine collection
- <sub>3</sub> Ineligible due to inpatient blood and urine collection
- <sub>4</sub> Ineligible (unrelated to blood/urine collection) prior to three-month visit
- <sub>5</sub> Ineligible at three-month visit
- <sub>6</sub> No longer willing to follow the protocol/interested in participating
- <sub>7</sub> Lost to follow-up
- <sub>8</sub> Participant has personal constraints
- <sub>9</sub> Deceased
- <sub>96</sub> Other  
(SPECIFY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_)

1b. Date Completed/Withdrawn/Died

(1020) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

1c. Did the participant request any specimen(s) to be disposed or autoclaved?

(1030) <sub>1</sub> Yes <sub>0</sub> No

IF **YES**: WHICH SPECIMENS DID THE  
PARTICIPANT WANT DISPOSED?

1ci. Serum/Plasma

(1040) <sub>1</sub> Yes <sub>0</sub> No

1cii. DNA samples

(1050) <sub>1</sub> Yes <sub>0</sub> No

1ciii. Urine

(1060) <sub>1</sub> Yes <sub>0</sub> No

**Comments:**

(6000) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

