



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

ASSESS AKI
ADULT
INPATIENT PROCEDURE
EVENT REVIEWER
FORM

Participant ID: __ - __ - __

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

EA TRACKING NUMBER: _____

1. Did the participant have any of the following procedures?
(PLEASE ANSWER YES OR NO TO EACH OF THE FOLLOWING)

- | | | | |
|--|--------|---|--|
| 1a. Coronary artery bypass surgery | (1000) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 1b. Percutaneous coronary intervention | (1010) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 1c. Peripheral artery intervention | (1020) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 1d. Lower extremity/digit amputation (more than one digit) | (1030) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 1e. Carotid artery revascularization (angioplasty, stenting, carotid endarterectomy) | (1040) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 1f. Implantation of cardioverter defibrillator | (1050) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 1g. Abdominal aortic aneurysm repair | (1060) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |

Comments:

(6000):





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

ASSESS AKI AKI EVALUATION

Participant ID: ____ - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

1. Record the admission date of the hospitalization (995) ____ / ____ / ____
MM DD YYYY
2. Date of last outpatient serum creatinine test (1000) ____ / ____ / ____
MM DD YYYY
3. Serum creatinine value (1010) ____ . ____
- 3a. Unit of measurement (1020) ☐₁ mg/dL
☐₂ umol/L
4. Did the participant have oliguria on the day of meeting the AKI criteria? (1025) ☐₁ Yes ☐₀ No ☐₉₇ N/A
5. Inpatient acute dialysis IF **NO**, STOP HERE. (1030) ☐₁ Yes ☐₀ No
- IF **YES**:
 - 5a. Start date for first dialysis (1040) ____ / ____ / ____
MM DD YYYY
 - 5b. Stop date for last dialysis (1050) ____ / ____ / ____
MM DD YYYY
 - 5c. Modality (PLEASE ANSWER YES OR NO TO EACH MODALITY)
 - Intermittent Hemodialysis (IHD) (1060) ☐₁ Yes ☐₀ No
 - Sustained Low-Efficiency Dialysis (SLED) (1070) ☐₁ Yes ☐₀ No
 - Continuous Renal Replacement Therapy (CRRT) (1080) ☐₁ Yes ☐₀ No
 - Peritoneal Dialysis (PD) (1090) ☐₁ Yes ☐₀ No
 - 5d. Was the participant discharged from the hospital requiring dialysis treatment? (1100) ☐₁ Yes ☐₀ No

Comments:

(6000) : _____



ASSESS AKI BLOOD PRESSURE

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ - __ - __

Visit Number: __ - __ - __

Visit Date: __ / __ / __ - __ - __

Coordinator ID: __ - __ - __ - __ - __

1. Was blood pressure taken at this visit?

(1000) ☐₁ Yes ☐₀ No

→ IF **NO**, COMPLETE QUESTION 1A AND **STOP**.

1a. What was the reason blood pressure could not be taken?

(1010) ☐₁ Equipment failure, specify

☐₂ Participant refusal

☐₃ Coordinator oversight

☐₉₆ Other _____

2. Time of day when seated blood pressure taken
RECORD USING 24 HOUR **CLOCK**

(1020) _____

3. Where was blood pressure taken?

(1030) ☐₁ Hospital clinic visit

☐₂ Study/research center office

☐₃ Clinic visit outside hospital

☐₄ Home

☐₉₆ Other (SPECIFY: _____
_____)

4. Blood pressure device number

(1040) _____

5. Arm used

(1050) ☐₁ Right ☐₂ Left

6. Midpoint circumference of arm used

(1060) _____ . _____ cm

7. Size of cuff

(1070) ☐₁ Small infant (7.0 to < 9.0 cm)

☐₂ Infant (9.0 to < 12.0 cm)

☐₃ Small child (12.0 to < 16.0 cm)

☐₄ Child (16 to < 20.0 cm)

☐₅ Small adult (20.0 to < 24.0 cm)

☐₆ Adult (24.0 to < 33.0 cm)

☐₇ Large adult (33.0 to 41.0 cm)

☐₈ Thigh (> 41.0 cm to 50.0 cm)

☐₉ Thigh (> 50.0 cm)





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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 95th 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
CANADA
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. LKC:	(1010)	__ . __ 10 ⁹ /L
2b. Platelets:	(1020)	__ 10 ⁹ /L
2c. Hemoglobin:	(1030)	__ . __ g/L
2d. Hematocrit:	(1040)	__ . __ L/L

3. Renal function (VISIT 3M ONLY)

3a. Creatinine	(1050)	__ . __ umol/L
----------------	--------	----------------

Comments:

(6000) : _____





ASsessment,
Serial Evaluation, and
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ASSESS AKI
CANADA
SERUM CREATININE
FROM OTHER SOURCES

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ __ __

Visit Number: __ __ __

Visit Date: __ / __ / __ - __ - __

Coordinator ID: __ __ __ __

This form records the serum creatinine value in the outpatient phase that was processed and provided by other sources and was not provided by the ASSESS-AKI Central Lab.

1. Source of authorization to obtain results: (1000) ☐₁ Consent
☐₂ Medical records release
2. Is this an outpatient, non-emergency department test value nearest to the in-person ASSESS value?
➔ If **NO** or **DON'T KNOW**, STOP HERE. (1010) ☐₁ Yes
☐₀ No
☐₉₈ Don't Know
3. Date of blood collection: (1020) __ / __ / __ - __ - __
MM DD YYYY
4. Serum creatinine (1030) __ . __ umol/L

Comments:

(6000) : _____





ASsessment,
Serial Evaluation, and
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ASSESS AKI CEREBROVASCULAR EVENT REVIEWER FORM

Participant ID: ____ - ____ - ____
Participant Initials: ____
Visit Number: ____
Admission Date: ____
Reviewer Initials: ____

EA TRACKING NUMBER: _____

DO NOT COMPLETE THIS FORM FOR EVENTS COLLECTED ON PEDIATRIC PARTICIPANTS

1. How is the event being adjudicated? (995) ☐₁ Local
☐₂ Central
2. How would you characterize this event outcome using all available information in this medical record? (1000) ☐₁ No cerebrovascular event
☐₂ Probable cerebrovascular event
☐₃ Definite cerebrovascular event
- ➔ If **NO CEREBROVASCULAR EVENT**, STOP HERE.
3. According to the ASSESS-AKI event definitions, this cerebrovascular event was a/an: (SELECT ONLY ONE) (1010) ☐₁ Intraparenchymal hemorrhage (IPH)
☐₂ Subarachnoid hemorrhage (SAH)
☐₃ Ischemic stroke
☐₉₆ Other (SPECIFY)
(1010D) _____
4. Was there a second cerebrovascular event during the hospitalization? (1020) ☐₁ Yes ☐₀ No
- ➔ If **YES**, PROCEED TO QUESTION 4a
➔ If **NO**, PROCEED TO QUESTION 5
- 4a. According to the ASSESS-AKI events definitions, this cerebrovascular event was a/an: (SELECT ONLY ONE) (1030) ☐₁ Intraparenchymal hemorrhage (IPH)
☐₂ Subarachnoid hemorrhage (SAH)
☐₃ Ischemic stroke
☐₉₆ Other (SPECIFY)
(1030D) _____
- 4ai. Please categorize probability for the cerebrovascular event. (1040) ☐₁ No cerebrovascular event
☐₂ Probable cerebrovascular event
☐₃ Definite cerebrovascular event





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ASSESS AKI
CEREBROVASCULAR
EVENT REVIEWER
FORM

Participant ID: __ - __ - __

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

5. Did the participant die before hospital discharge?

(1050)

☐

₁ Yes

☐

₀ No

☐

₉₈ Don't know

Comments:

(6000):





ASsessment,
Serial Evaluation, and
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NIH/NIDDK

ASSESS AKI CEREBROVASCULAR EVENT REVIEWER FORM

Participant ID: __ - __ - __
Participant Initials: ____
Visit Number: ____
Admission Date: ____
Reviewer Initials: ____

CRITERIA FOR CEREBROVASCULAR EVENTS

All events that are abstracted will be screened for intracranial hemorrhage (both intracerebral bleeding, subarachnoid hemorrhage, and subdural hematoma). If these are negative, then they will receive a cerebral infarction determination and subtype determination, if appropriate.

Definition of major neurological signs and symptoms:

1. Hemiparesis involving two or more body parts
2. Homonymous hemianopsia
3. Aphasia
4. Neglect

Definition of minor neurological signs and symptoms:

1. Diplopia
2. Vertigo or gait disturbance
3. Dysarthria, dysphagia, or dysphonia
4. Hemisensory loss involving two or more body parts
5. Ataxia

Criteria for Intracerebral Hemorrhage

1. Autopsy or surgery proven intra-parenchymal hemorrhage or subarachnoid hemorrhage.
OR
2. Sudden or rapid onset of severe headache with or without any neurologic signs or symptoms lasting for more than 24 hours or until the participant died, plus evidence of intraparenchymal hematoma without subarachnoid hemorrhage seen on head CT or MRI. (Intraventricular hemorrhage may occur with IPH or SAH and does not affect classification.)

Likelihood of Stroke Determination

Definition of Definite Stroke

1. Sudden or rapid onset of one major or two minor neurologic signs or symptoms within a single vascular territory lasting for more than 24 hours or until the participant died, without an alternative etiology. CT or MRI findings may be equivocal or test results not available.
OR
2. Symptoms consistent with an acute ischemic stroke and either (A) autopsy proven nonhemorrhagic infarction in the brain or (B) CT or MRI demonstration of an acute infarct (e.g., hypoattenuation on CT, increased signal on MRI T2, FLAIR, or DWI) in the appropriate vascular territory.





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ASSESS AKI
CEREBROVASCULAR
EVENT REVIEWER
FORM

Participant ID: __ - __ - __

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

Definition of Probable Stroke

1. Sudden or rapid onset of one major or two minor neurologic signs or symptoms within a single vascular territory without an alternative etiology but where the duration of symptoms is not confirmed to be lasting more than 24 hours or until the participant died. CT or MRI may be equivocal or not available.

OR

2. Sudden or rapid onset of one major or two minor neurologic signs or symptoms within a single vascular territory lasting more than 24 hours or until the participant died but where it is unclear if there is an alternative etiology. CT or MRI may be equivocal or not available.

Definition of Improbable Stroke

1. No evidence of infarct (hypoattenuation on CT, increased signal on MRI T2, FLAIR, or DWI) in appropriate territory.

AND

2. Clinical presentation not consistent with stroke:
 - a. Only one minor neurologic sign or symptom
 - b. Constellation of symptoms does not fit a single vascular territory.
 - c. Waxing and waning neurologic symptoms or progressive accumulation of neurologic symptoms over time

Definition of Can't Determine Stroke:

1. Inadequate documentation of clinical presentation

AND

2. No head CT, MRI or autopsy performed



ASSESS AKI CEREBROVASCULAR EVENT REVIEWER FORM

Participant ID: __ - __ - __

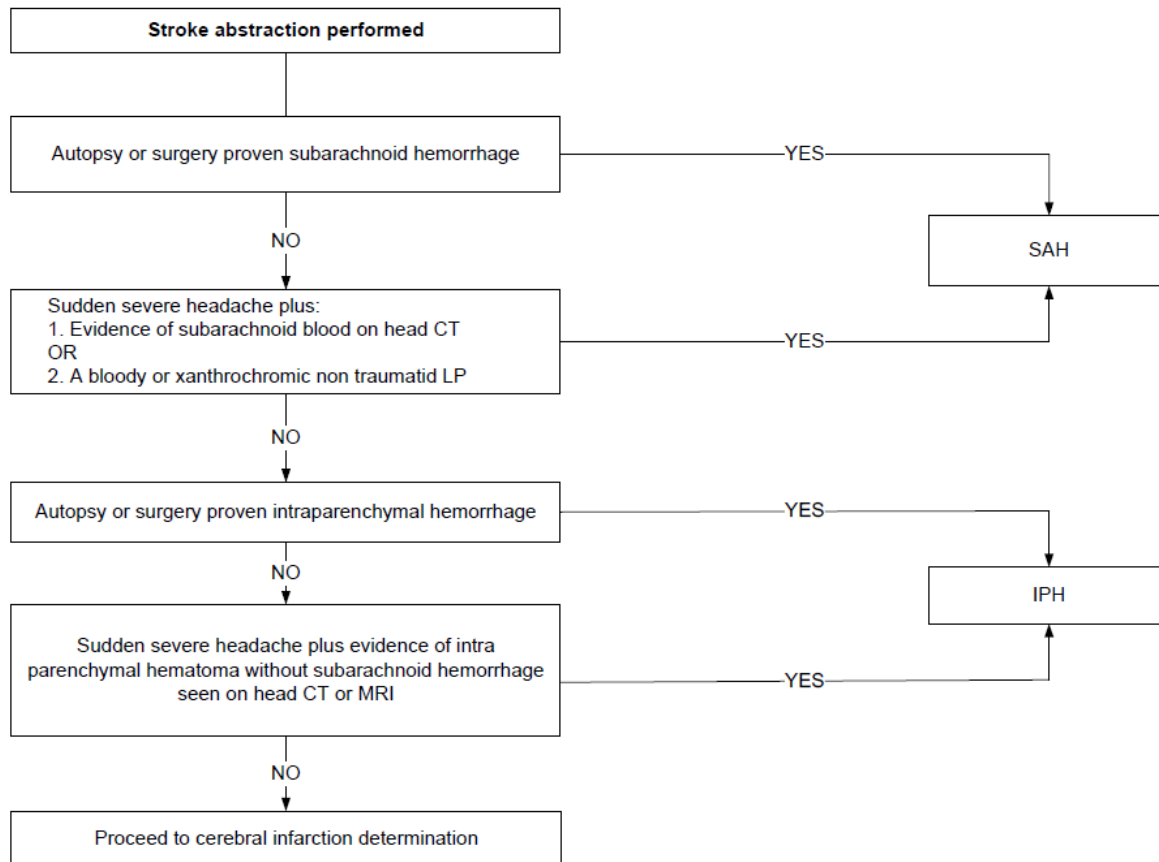
Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

The schematic below provides a general flow for evaluating possible intracranial hemorrhage and ischemic strokes/cerebral infarctions:





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ASSESS AKI CEREBROVASCULAR EVENT REVIEWER FORM

Participant ID: __ - 4A - ____
Participant Initials: ____
Visit Number: ____
Admission Date: ____
Reviewer Initials: ____

EA TRACKING NUMBER: _____

DO NOT COMPLETE THIS FORM FOR EVENTS COLLECTED ON PEDIATRIC PARTICIPANTS

1. If a disagreement resolution occurred what is the final consensus of the group regarding this event? (1060)
- ☐₁ No cerebrovascular event
☐₂ Probable cerebrovascular event
☐₃ Definite cerebrovascular event
- ➔ If **NO CEREBROVASCULAR EVENT**, STOP HERE.
2. If there was a second cerebrovascular event what is the final consensus of the group regarding the second event? (1070)
- ☐₁ No cerebrovascular event
☐₂ Probable cerebrovascular event
☐₃ Definite cerebrovascular event

Comments:

(6000):

Submit





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ASSESS AKI CEREBROVASCULAR EVENT REVIEWER FORM

Participant ID: __ - __ - __

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

CRITERIA FOR CEREBROVASCULAR EVENTS

All events that are abstracted will be screened for intracranial hemorrhage (both intracerebral bleeding, subarachnoid hemorrhage, and subdural hematoma). If these are negative, then they will receive a cerebral infarction determination and subtype determination, if appropriate.

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NIH/NIDDK

ASSESS AKI
CEREBROVASCULAR
EVENT REVIEWER
FORM

Participant ID: __ - __ - __

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

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OR

2. Sudden or rapid onset of one major or two minor neurologic signs or symptoms within a single vascular territory lasting more than 24 hours or until the participant died but where it is unclear if there is an alternative etiology. CT or MRI may be equivocal or not available.

Definition of Improbable Stroke

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AND

2. Clinical presentation not consistent with stroke:
 - a. Only one minor neurologic sign or symptom
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Definition of Can't Determine Stroke:

1. Inadequate documentation of clinical presentation

AND

2. No head CT, MRI or autopsy performed



ASSESS AKI CEREBROVASCULAR EVENT REVIEWER FORM

Participant ID: __ - __ - __

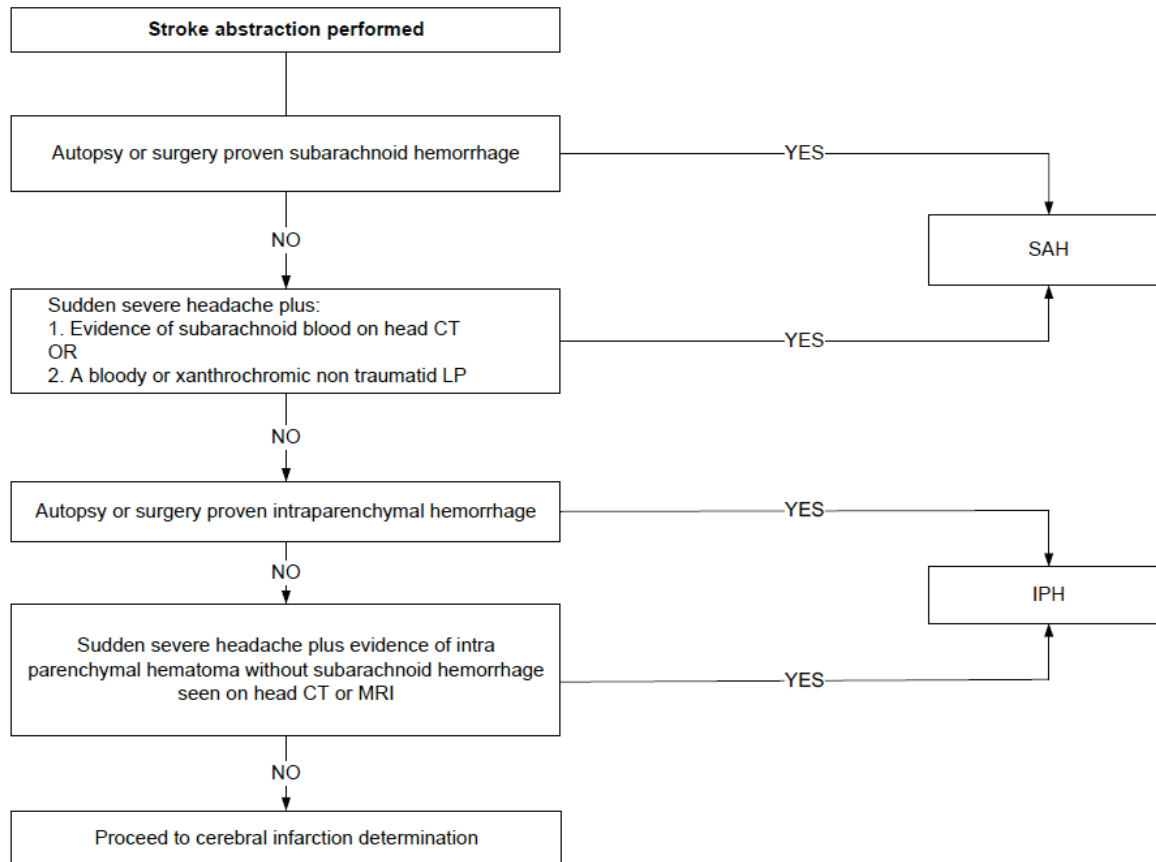
Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

The schematic below provides a general flow for evaluating possible intracranial hemorrhage and ischemic strokes/cerebral infarctions:





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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"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>
___	___	_____	_____	___ / ___ / ___	<input type="checkbox"/>





ASsessment,
Serial Evaluation, and
Subsequent 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
2. Fish oil supplements (1010) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
(Omega-3 Oils, Omega-3 Fatty-Acids)
3. Non-steroidal anti-inflammatory drugs (NSAIDs) (1020) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
➔ USE CMED_OTC REFERENCE CARD

Comments:

(6000) : _____





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae 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) ☐₁ Inside the hospital or ER

☐₂ Outside the hospital or ER

Comments:

(6000) : _____





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

**ASSESS AKI
OUTPATIENT
DIALYSIS EVALUATION**

Participant ID: __ - __ - __

Participant Initials: __ __

Visit Number: __ __

Visit Date: __ / __ / __

Coordinator ID: __ __

1. Start date for first dialysis (1000) __ / __ / __
MM DD YYYY
2. Modality
- 2a. Intermittent Hemodialysis (IHD) (1010) ☐₁ Yes ☐₀ No
- 2b. Peritoneal Dialysis (PD) (1020) ☐₁ Yes ☐₀ No
3. Did the participant completely stop dialysis (1030) ☐₁ Yes ☐₀ No
- 3a. If YES, what date did dialysis stop? (1040) __ / __ / __
MM DD YYYY

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) ☐₁ Negative
☐₂ Trace
☐₃ 30 (+)
☐₄ 100 (++)
☐₅ ≥ 300 (+++)

1c. Glucose

(1020) ☐₁ Negative
☐₂ 100
☐₃ 250
☐₄ 500
☐₅ ≥ 1000

1d. Ketones

(1030) ☐₁ Negative
☐₂ Trace
☐₃ 15 (small)
☐₄ 40 (moderate)
☐₅ 80 (large)
☐₆ ≥ 160

1e. Leukocyte Esterase

(1040) ☐₁ Negative
☐₂ Trace
☐₃ Small
☐₄ Moderate
☐₅ Large

1f. Blood

(1050) ☐₁ Negative
☐₂ Trace-lysed
☐₃ Trace-intact
☐₄ Small (+)
☐₅ Moderate (++)
☐₆ Large (+++)





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ASSESS AKI URINE DIPSTICK RESULTS

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ __ __

Visit Number: __ __ __

Visit Date: __ / __ / __ - __ - __

Coordinator ID: __ __ __ __

1g. Nitrites

(1060) ☐₁ Pos ☐₀ Neg

1h. pH level

(1070) ☐₁ ≤ 5.5
☐₂ 6.0
☐₃ 6.5
☐₄ 7.0
☐₅ ≥ 7.5

Comments:

(6000) : _____





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

ASSESS AKI DNA CONSENT

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ __ __

Visit Number: __ __ __

Visit Date: __ / __ / __ - __ - __

Coordinator ID: __ __ __ - __

1. Did the participant give permission to prepare DNA from his/her blood samples? (1000) ☐₁ Yes ☐₀ No
2. Did the participant give permission to create a cell line from his/her blood cells? (1010) ☐₁ Yes ☐₀ No
3. 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) ☐₁ Yes ☐₀ No
4. Did the participant give permission to test his/her DNA for genes related to other health conditions? (1030) ☐₁ Yes ☐₀ No

Comments:

(6000) : _____



ASessment,
Serial **E**valuation, and
Subsequent **S**equelae 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?
KAISER SITE: IF YES, PROCEED TO QUESTION 6. (995) ☐₁ Yes ☐₀ No
2. Did the participant give permission to prepare DNA from his/her blood samples? (1000) ☐₁ Yes ☐₀ No
3. Did the participant give permission to create a cell line from his/her blood cells? (1010) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No
5. Did the participant give permission to test his/her DNA for genes related to other health conditions? (1030) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

Comments:

(6000) : _____





ASsessment,
Serial Evaluation, and
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NIH/NIDDK

ASSESS AKI ECG CLINIC

Participant ID: 1 - - - - -

Participant Initials: - - - - -

Visit Number: - - - - -

Visit Date: - - - / - - - / - - - - -

Coordinator ID: - - - - -

1. Was an ECG performed at this visit?

(1000) ☐₁ Yes ☐₀ No

➔ If **NO**, COMPLETE QUESTION 1A AND **STOP**.

1a. What was the reason an ECG could not be performed?

(1010) ☐₁ Equipment failure, specify

☐₂ Participant refusal

☐₃ Coordinator oversight

☐₉₆ Other _____

2. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home?

(1015) ☐₁ Yes ☐₀ No

3. Did the ECG indicate one of the following conditions?

3a. Acute Myocardial Infarction or acute ischemia

(1020) ☐₁ Yes ☐₀ No

3b. Ventricular Tachycardia/Ventricular Fibrillation

(1030) ☐₁ Yes ☐₀ No

3c. Atrial Fibrillation (if new since previous ECG)

(1040) ☐₁ Yes ☐₀ No

3d. Atrial Flutter (if new since previous ECG)

(1050) ☐₁ Yes ☐₀ No

3e. Complete Atrioventricular Block

(1060) ☐₁ Yes ☐₀ No

3f. Bradycardia (<45 beats/min)

(1070) ☐₁ Yes ☐₀ 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) _____





ASessment,
Serial Evaluation, and
Subsequent Sequelae in AKI
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)

☐

₁

Consent

☐

₂

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 HOSPITAL/ER RECORD EVALUATION

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ __ __

Visit Number: __ __ __

Visit Date: __ / __ / __ - __ - __

Coordinator ID: __ __ __ - __ __

COORDINATORS SHOULD COMPLETE A SEPARATE HOSPITAL RECORD EVALUATION (HOSP_EVAL) FORM FOR EACH HOSPITALIZATION.

1. Was the hospitalization documented in Question 1 on the Medical Events (P1_EVENTS, P2_EVENTS) form?
➔ IF **NO**, SKIP QUESTIONS 1b and 1c.
(1000) ☐₁ Yes ☐₀ No
- 1a. What is the primary reason for the hospitalization?
(CLASSIFY THE TYPE OF EVENT USING THE ANNOTATION FROM Q1a-1k ON THE MEDICAL EVENTS [P1_EVENTS, P2_EVENTS] FORM)
(1010) __ __ __ __
- 1b. What is the admission date reported by the participant/informant?
(1020) __ __ / __ __ / __ __ __ __
MM DD YYYY
- 1c. What is the discharge/death date reported by the participant/informant?
(1030) __ __ / __ __ / __ __ __ __
MM DD YYYY
- 1d. Were you previously notified of this hospitalization?
(1040) ☐₁ Yes ☐₀ No
2. Did you identify and obtain hospital records (any medical records i.e., discharge summary, progress notes, laboratory results, etc. and/or administrative hospital codes) for this hospitalization?
➔ IF **NO**, STOP HERE. This form should not be data entered if medical records cannot be obtained
(1050) ☐₁ Yes ☐₀ No
- 2a. What is the admission date?
(1060) __ __ / __ __ / __ __ __ __
MM DD YYYY
- 2b. What is the discharge/death date?
(1070) __ __ / __ __ / __ __ __ __
MM DD YYYY
3. Inpatient acute dialysis
(1075) ☐₁ Yes ☐₀ No ☐₈₈ Uncertain
4. Were any ASSESS-AKI ICD9 codes identified in the hospital records?
➔ IF **YES**, COMPLETE THE ICD9/CPT ADMINISTRATIVE CODES (ICD9_CPT_CODES) SHEET
(1080) ☐₁ Yes ☐₀ No
5. Were any ASSESS-AKI ICD10 codes identified in the hospital records?
➔ IF **YES**, COMPLETE THE ICD10/CCI ADMINISTRATIVE CODES (ICD10_CCI_CODES) SHEET
(1090) ☐₁ Yes ☐₀ No





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) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ 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"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8b. Myocardial infarction | (1120) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8c. Heart failure | (1130) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8d. Ischemic stroke or transient ischemic attack | (1140) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8e. Hemorrhagic stroke or intracranial hemorrhage | (1150) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8f. Blockage in the arteries of the arms, legs, or abdomen | (1160) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8g. Coronary artery bypass surgery | (1190) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8h. Percutaneous coronary intervention | (1200) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8i. Peripheral artery intervention | (1210) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |
| 8j. Lower extremity/digit amputation | (1220) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Unknown |





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: __ __ __ - __ __

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

8l. Implantation of cardioverter defibrillator (1240) ☐₁ Yes ☐₀ No ☐₉₈ Unknown

8m. Kidney transplant (1260) ☐₁ Yes ☐₀ No ☐₉₈ Unknown

Comments:

(6000) : _____





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

ASSESS AKI
ICD9/CPT
ADMINISTRATIVE
CODES SHEET

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ - __ - __

Visit Number: __ - __ - __

Visit Date: __ / __ / __ - __ - __

Coordinator ID: __ - __ - __ - __ - __

1. Record the admission date of the hospitalization.

(1000) __ / __ / __ - __ - __
MM DD YYYY

LIST ALL ASSESS-AKI ICD9 or CPT CODES IN THE ORDER THEY ARE RECORDED ON THE PARTICIPANT'S HOSPITAL RECORDS.

Record ID (1010)	ICD9 code (1020)	CPT code (1030)
__ - __	__ - __ - __ . __ - __	__ - __ - __ - __ - __
__ - __	__ - __ - __ . __ - __	__ - __ - __ - __ - __
__ - __	__ - __ - __ . __ - __	__ - __ - __ - __ - __
__ - __	__ - __ - __ . __ - __	__ - __ - __ - __ - __
__ - __	__ - __ - __ . __ - __	__ - __ - __ - __ - __
__ - __	__ - __ - __ . __ - __	__ - __ - __ - __ - __
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__ - __	__ - __ - __ . __ - __	__ - __ - __ - __ - __
__ - __	__ - __ - __ . __ - __	__ - __ - __ - __ - __

Comments:

(6000) : _____





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

ASSESS AKI
ICD10/CCI
ADMINISTRATIVE
CODES SHEET

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ __ __

Visit Number: __ __ __

Visit Date: __ / __ / __

Coordinator ID: __ __ __

1. Record the admission date of the hospitalization.

(1000) __ / __ / __
MM DD YYYY

LIST ALL ASSESS-AKI ICD10 or CCI CODES IN THE ORDER THEY ARE RECORDED ON THE PARTICIPANT'S HOSPITAL RECORDS.

Record ID (1010)	ICD10 code (1020)	CCI code (1030)
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __
__ __	__ __ __ __ __	__ __ __ __ __

Comments:

(6000) : _____





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

ASSESS AKI INPATIENT HEART FAILURE EVENT REVIEWER FORM

Participant ID: ____ - ____ - ____

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

EA TRACKING NUMBER: _____

1. How is the event being adjudicated? (995) ☐₁ Local
☐₂ Central

COMPLETE QUESTION 2 FOR EVENTS COLLECTED ON ADULT PARTICIPANTS

2. Is there documentation of clinical symptoms (dyspnea on exertion or rest, paroxysmal nocturnal dyspnea, and/or orthopnea)? (1000) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

COMPLETE QUESTION 3 FOR EVENTS COLLECTED ON PEDIATRIC PARTICIPANTS

3. Is there documentation of clinical symptoms (dyspnea, tachypnea, poor feeding, and abdominal pain)? (1010) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
4. Do notes or radiology reports document radiographic evidence of pulmonary edema or pulmonary congestion? (1020) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

DO NOT COMPLETE QUESTION 5c FOR EVENTS COLLECTED ON PEDIATRIC PARTICIPANTS

5. Physical exam findings to include at least two of the following:
- 5a. Inspiratory crackles ("rales") (1030) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 5b. S3 gallop on auscultation (1040) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 5c. Jugular venous distention (1050) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 5d. Peripheral edema (1060) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 5e. Hepatojugular reflux (1070) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 5f. Hepatomegaly (1080) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 5g. Tachycardia (heart rate > 120) (1090) ☐₁ Yes ☐₀ No ☐₉₈ Don't know





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

ASSESS AKI INPATIENT HEART FAILURE EVENT REVIEWER FORM

Participant ID: __ - __ - __

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

6. Invasive hemodynamic or echocardiogram evidence including any of the following:
(PLEASE ANSWER YES, NO, OR DON'T KNOW TO EACH OF THE FOLLOWING)

6a. Pulmonary capillary wedge pressure > 18 mm Hg (1100) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

6b. Cardiac index < 2.0 L/min/M² (1110) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

6c. Left ventricular ejection fraction ≤ 35% (1120) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

7. How would you characterize this event using all available information in this medical record? (1130) ☐₁ Definite heart failure
☐₂ Probable heart failure
☐₃ Not heart failure

8. Did the participant die before hospital discharge? (1140) ☐₁ Yes
☐₀ No
☐₉₈ Don't know

Comments:
(6000):





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

ASSESS AKI INPATIENT HEART FAILURE EVENT REVIEWER FORM

Participant ID: __ - __ - __

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

Heart Failure Criteria For Events Collected On Adult Participants

Diagnosis of CHF requires the simultaneous presence of at least 2 major criteria or 1 major criterion in conjunction with 2 minor criteria.

Minor criteria are acceptable only if they cannot be attributed to another medical condition (such as pulmonary hypertension, chronic lung disease, cirrhosis, ascites, or the nephrotic syndrome).

Major Criteria

- Paroxysmal nocturnal dyspnea
- Neck vein distention
- Rales
- Radiographic cardiomegaly (increasing heart size on chest radiography)
- Acute pulmonary edema
- S3 gallop
- Increased central venous pressure (>16cm H₂O at right atrium), if measured
- Hepatojugular reflux
- Weight loss >4.5 kg in 5 days in response to treatment

Minor Criteria

- Bilateral ankle edema
- Nocturnal cough
- Dyspnea on ordinary exertion
- Hepatomegaly
- Pleural effusion
- Decrease in vital capacity by one third from maximum recorded
- Tachycardia (heart rate >120 beats/min)





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

ASSESS AKI INPATIENT HEART FAILURE EVENT REVIEWER FORM

Participant ID: __ - 4A - ____

Participant Initials: ____

Visit Number: ____

Admission Date: ____

Reviewer Initials: ____

EA TRACKING NUMBER: _____

1. How would you characterize this event using all available information in this medical record?

(1150)

- ☐₁ Definite heart failure
☐₂ Probable heart failure
☐₃ Not heart failure

Comments:
(6000):

Submit





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

ASSESS AKI INPATIENT HEART FAILURE EVENT REVIEWER FORM

Participant ID: __ - __ - __

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

Heart Failure Criteria For Events Collected On Adult Participants

Diagnosis of CHF requires the simultaneous presence of at least 2 major criteria or 1 major criterion in conjunction with 2 minor criteria.

Minor criteria are acceptable only if they cannot be attributed to another medical condition (such as pulmonary hypertension, chronic lung disease, cirrhosis, ascites, or the nephrotic syndrome).

Major Criteria

- Paroxysmal nocturnal dyspnea
- Neck vein distention
- Rales
- Radiographic cardiomegaly (increasing heart size on chest radiography)
- Acute pulmonary edema
- S3 gallop
- Increased central venous pressure (>16cm H₂O at right atrium), if measured
- Hepatojugular reflux
- Weight loss >4.5 kg in 5 days in response to treatment

Minor Criteria

- Bilateral ankle edema
- Nocturnal cough
- Dyspnea on ordinary exertion
- Hepatomegaly
- Pleural effusion
- Decrease in vital capacity by one third from maximum recorded
- Tachycardia (heart rate >120 beats/min)





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"/> ₁ mg/dL <input type="checkbox"/> ₂ umol/L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L
____	____ / ____ / ____	____	____ . ____	<input type="checkbox"/> ₁ mg/dL <input type="checkbox"/> ₂ umol /L

Comments:

(6000) : _____





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

ASSESS AKI MYOCARDIAL INFARCTION EVENT REVIEWER FORM

Participant ID: ____ - ____ - ____
Participant Initials: ____
Visit Number: ____
Admission Date: ____
Reviewer Initials: ____

EA TRACKING NUMBER: _____

DO NOT COMPLETE THIS FORM FOR EVENTS COLLECTED ON PEDIATRIC PARTICIPANTS

1. How is the event being adjudicated? (995) ☐₁ Local ☐₂ Central

GUIDANCE FOR DEFINING ABNORMALITIES THRESHOLD FOR THE LAB USING QUESTION 2.
PLEASE PROVIDE A RESPONSE FOR EACH QUESTION.

2. Were any Troponin I values available? (1000) ☐₁ Yes ☐₀ No

→ IF **YES**, PROCEED TO QUESTION 3

→ IF **NO**, PROCEED TO QUESTION 6

3. List the upper reference limit for the Troponin I assay from the hospital laboratory:

3a. Upper reference limit (URL) (1030) ____ . ____

3ai. Units

(1040) ☐₁ ng/mL ☐₂ mcg/L

4. List the peak Troponin I value from the hospitalization (including any ED test results):

(1050) ____ . ____

4a. Units

(1060) ☐₁ ng/mL ☐₂ mcg/L

5. Did the participant undergo coronary revascularization before the peak Troponin I value?

(1070) ☐₁ Yes ☐₀ No

5a. IF **YES**, CHECK ONLY ONE ANSWER

(1080) ☐₁ Coronary angioplasty (including angioplasty with stenting, antherectomy)

☐₂ Coronary artery bypass graft

☐₉₆ Other

(1080D) SPECIFY _____





ASessment,
Serial Evaluation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

ASSESS AKI MYOCARDIAL INFARCTION EVENT REVIEWER FORM

Participant ID: ____ - ____ - ____
Participant Initials: ____
Visit Number: ____
Admission Date: ____
Reviewer Initials: ____

6. Were any symptoms consistent with acute cardiac ischemia present? (1090) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

→ IF **YES**, PROCEED TO QUESTION 7
→ IF **NO**, PROCEED TO QUESTION 8
→ IF **DON'T KNOW**, PROCEED TO QUESTION 9

7. Guidance for myocardial infarction determination based on Troponin I data, ECG findings, and the PRESENCE of acute cardiac ischemia symptoms (SELECT ONLY ONE AND THEN PROCEED TO QUESTION 9).

(1100)	Peak Troponin I Classification		
ECG Pattern	Abnormal	Normal/Equivocal	Missing
Evolving Diagnostic ECG (Evolution of major Q-wave)	<input type="checkbox"/> ₁ Definite MI	<input type="checkbox"/> ₂ Definite MI	<input type="checkbox"/> ₃ Definite MI
Positive ECG (Evolution of ST <u>Elevation</u> with or without Q-wave OR new LBBB)	<input type="checkbox"/> ₄ Definite MI	<input type="checkbox"/> ₅ No MI	<input type="checkbox"/> ₆ Definite MI
Non-specific ECG (Evolution of ST-T <u>Depression</u> / inversion alone OR evolution or minor Q-waves alone)	<input type="checkbox"/> ₇ Definite MI	<input type="checkbox"/> ₈ No MI	<input type="checkbox"/> ₉ No MI
ECG Negative for Ischemia Normal, Absent, Uncodable, or Other	<input type="checkbox"/> ₁₀ Definite MI	<input type="checkbox"/> ₁₁ No MI	<input type="checkbox"/> ₁₂ No MI

8. Guidance for myocardial infarction determination based on Troponin I data, ECG findings, and the ABSENCE of acute ischemia symptoms (SELECT ONLY ONE).

(1110)	Troponin I Classification		
ECG Pattern	Abnormal	Normal/Equivocal	Missing
Evolving Diagnostic ECG (Evolution of major Q-wave)	<input type="checkbox"/> ₁ Definite MI	<input type="checkbox"/> ₂ Definite MI	<input type="checkbox"/> ₃ Definite MI
Positive ECG (Evolution of ST <u>Elevation</u> with or without Q-wave OR new LBBB)	<input type="checkbox"/> ₄ Definite MI	<input type="checkbox"/> ₅ No MI	<input type="checkbox"/> ₆ Possible MI
Non-specific ECG (Evolution of ST-T <u>Depression</u> / inversion alone OR evolution or minor Q-waves alone)	<input type="checkbox"/> ₇ Definite MI	<input type="checkbox"/> ₈ No MI	<input type="checkbox"/> ₉ No MI
ECG Negative for Ischemia Normal, Absent, Uncodable, or Other	<input type="checkbox"/> ₁₀ Definite MI	<input type="checkbox"/> ₁₁ No MI	<input type="checkbox"/> ₁₂ No MI





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

ASSESS AKI MYOCARDIAL INFARCTION EVENT REVIEWER FORM

Participant ID: ____ - ____ - ____

Participant Initials: _____

Visit Number: _____

Admission Date: _____

Reviewer Initials: _____

9. What is your global impression of the final outcome using all available information in this medical record? (1120)
- ☐₁ No MI
☐₂ Probable MI
☐₃ Definite MI
10. What was the participant's vital status at the discharge? (1130)
- ☐₀ Dead
☐₁ Alive
☐₉₈ Don't know

Comments
(6000):

Criteria for Acute Myocardial Infarction

The term myocardial infarction should be used when there is evidence of myocardial necrosis in a clinical setting consistent with myocardial ischaemia. Under these conditions any one of the following criteria meets the diagnosis for myocardial infarction:

- Detection of rise and/or fall of cardiac biomarkers (preferably troponin) with at least one value above the 99th percentile of the upper reference limit (URL) together with evidence of myocardial ischaemia with at least one of the following:
 - Symptoms of ischaemia;
 - ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]);
 - Development of pathological Q waves in the ECG;
 - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
- Sudden, unexpected cardiac death, involving cardiac arrest, often with symptoms suggestive of myocardial ischaemia, and accompanied by presumably new ST elevation, or new LBBB, and/or evidence of fresh thrombus by coronary angiography and/or at autopsy, but death occurring before blood samples could be obtained, or at a time before the appearance of cardiac biomarkers in the blood.
- Pathological findings of an acute myocardial infarction.

JACC Vol. 50, No. 22, 2007 Thygesen et al. 2175
November 27, 2007:2173–95 ESC/ACCF/AHA/WHF Expert Consensus Document





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

ASSESS AKI MYOCARDIAL INFARCTION EVENT REVIEWER FORM

Participant ID: __ - 4A - ____
Participant Initials: ____
Visit Number: ____
Admission Date: ____
Reviewer Initials: ____

EA TRACKING NUMBER: _____

1. If a disagreement resolution occurred what is the final consensus the group regarding this event?

(1140)

- ☐₁ No MI
☐₂ Probable MI
☐₃ Definite MI

Comments

(6000):

Criteria for Acute Myocardial Infarction

Submit

The term myocardial infarction should be used when there is evidence of myocardial necrosis in a clinical setting consistent with myocardial ischaemia. Under these conditions any one of the following criteria meets the diagnosis for myocardial infarction:

- Detection of rise and/or fall of cardiac biomarkers (preferably troponin) with at least one value above the 99th percentile of the upper reference limit (URL) together with evidence of myocardial ischaemia with at least one of the following:
 - Symptoms of ischaemia;
 - ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]);
 - Development of pathological Q waves in the ECG;
 - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
- Sudden, unexpected cardiac death, involving cardiac arrest, often with symptoms suggestive of myocardial ischaemia, and accompanied by presumably new ST elevation, or new LBBB, and/or evidence of fresh thrombus by coronary angiography and/or at autopsy, but death occurring before blood samples could be obtained, or at a time before the appearance of cardiac biomarkers in the blood.
- Pathological findings of an acute myocardial infarction.

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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) ☐₁ Correct ☐₀ Incorrect

1b. Day _____ (1010) ☐₁ Correct ☐₀ Incorrect

1c. Year _____ (1020) ☐₁ Correct ☐₀ Incorrect

Where were you born?

1d. City/Town _____ (1030) ☐₁ Correct ☐₀ Incorrect

1e. State/County/Province _____ (1040) ☐₁ Correct ☐₀ 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) ☐₁ Correct ☐₀ Incorrect

2b. Blue (1070) ☐₁ Correct ☐₀ Incorrect

2c. Charity (1080) ☐₁ Correct ☐₀ 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) ☐ ₂ Accurate
☐ ₁ 1 – 2 Errors
☐ ₀ >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 'W O R L D'.")

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.





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: ____

5a. Socks

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

5b. Blue

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

5c. Charity

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

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

(1170) ____ (MAX. SCORE: 9)



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

Participant ID: 1 - - - - -

Participant Initials: - - - -

Visit Number: - - - -

Visit Date: - - / - - / - - - -

Coordinator ID: - - - - -

6. What is today's date?

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

- (1180) ☐₂ Accurate
☐₁ Within 1 month
☐₀ Inaccurate

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

- (1190) ☐₃ Accurate
☐₂ Within 2 days
☐₁ Within 3 - 5 days
☐₀ Inaccurate

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

- (1200) ☐₈ Accurate
☐₄ Within 1 year
☐₂ Within 2 - 5 years
☐₀ Inaccurate

6b. What is the day of the week?

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

- (1210) ☐₁ Correct ☐₀ Incorrect

6c. What season of the year is it?

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

- (1220) ☐₁ Correct ☐₀ 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) ☐₂ Correct ☐₀ Incorrect

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

7b. What country are we in?

(1250) ☐₁ Correct ☐₀ Incorrect

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

7c. What city/town are we in?

(1260) ☐₁ Correct ☐₀ Incorrect

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

7d. Are we in a clinic, store or home?

(1270) ☐₁ Correct ☐₀ 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) ☐₁ Correct ☐₀ Incorrect

8b. Chin: "...And this part?"

(1300) ☐₁ Correct ☐₀ Incorrect

8c. Shoulder: "...And this part of the body?"

(1310) ☐₁ Correct ☐₀ Incorrect

8d. Elbow: "...And this part?"

(1320) ☐₁ Correct ☐₀ Incorrect

8e. Knuckle: "...And this part of the hand?"

(1330) ☐₁ Correct ☐₀ 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.

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) ☐₂ Limbs, extremities
☐₁ Lesser correct answer, e.g., body part, both bend, have joints
☐₀ 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) ☐₂ Expressions of feelings, emotions
☐₁ Lesser correct answer, e.g., sounds, expressions
☐₀ Error, e.g., states differences, gives unrelated answer/refused



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

Participant ID: 1 - - - - -

Participant Initials: - - - -

Visit Number: - - - -

Visit Date: - - / - - / - - - -

Coordinator ID: - - - - -

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

- (1380) ☐₂ Necessary bodily functions, essential for life
☐₁ Lesser correct answer, e.g., bodily functions, relaxing, "good for you"
☐₀ 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) ☐₂ Correct
☐₁ 1 or 2 words missed
☐₀ 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) ☐₁ Correct ☐₀ Incorrect

12b. ands

(1430) ☐₁ Correct ☐₀ Incorrect

12c. or buts

(1440) ☐₁ Correct ☐₀ 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) ☐₃ Closes eyes without prompting
☐₂ Closes eyes after prompting
☐₁ Reads aloud, but does not close eyes
☐₀ 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."



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

Participant ID: 1 - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

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) ☐₁ Correct ☐₀ Incorrect

14b. like

(1490) ☐₁ Correct ☐₀ Incorrect

14c. to

(1500) ☐₁ Correct ☐₀ Incorrect

14d. go

(1510) ☐₁ Correct ☐₀ Incorrect

14e. out

(1520) ☐₁ Correct ☐₀ 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) ☐₄ 5 approximately equal sides
☐₃ 5 sides, but longest:shortest side is 2:1
☐₂ Non-pentagon enclosed figure
☐₁ 2 or more lines, but not an enclosure
☐₀ Less than 2 lines/refused

15b. Pentagon 2

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

15c. Intersection

- (1560) ☐₂ 4-cornered enclosure
☐₁ Other than 4-cornered enclosure
☐₀ 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) ☐₁ Correct ☐₀ Incorrect

16b. Folds paper in half

- (1590) ☐₁ Correct ☐₀ Incorrect

16c. Hands paper back

- (1600) ☐₁ Correct ☐₀ 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) ☐₃ Spontaneous recall
☐₂ Correct word/incorrect form
☐₂ After **“Something to wear.”**
☐₁ After **“Was it shirt, shoes or socks?”**
☐₀ Unable to recall/refused (provide the correct answer)

17b. Blue

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

17c. Charity

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

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

(1650) ____ (MAX. SCORE: 9)





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: ____

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*): _____





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

ASSESS AKI
MODIFIED MINI-MENTAL
STATE EXAM
PHONE VERSION

Participant ID: 1 - - - - -

Participant Initials: - - - -

Visit Number: - - - -

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) ☐₁ Correct ☐ None
☐₀ Incorrect ☐ Sight
☐₉₉ Refused ☐ Hearing
☐ Hands
☐ Other

RECORD FIRST RESPONSE

2. Who was the president before him?

- (1020) ☐₁ Correct ☐ None
☐₀ Incorrect ☐ Sight
☐₉₉ Refused ☐ Hearing
☐ Hands
☐ Other

RECORD FIRST RESPONSE

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

- (1040) ☐₁ Correct ☐ None
☐₀ Incorrect ☐ Sight
☐₉₉ Refused ☐ Hearing
☐ Hands
☐ Other

RECORD FIRST RESPONSE

4. Who was vice president before him?

- (1060) ☐₁ Correct ☐ None
☐₀ Incorrect ☐ Sight
☐₉₉ Refused ☐ Hearing
☐ Hands
☐ Other

RECORD FIRST RESPONSE

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

- (1080) ☐₁ Correct ☐ None
☐₀ Incorrect ☐ Sight
☐₉₉ Refused ☐ Hearing
☐ Hands
☐ Other

RECORD FIRST RESPONSE

Section Total

___ out of 5





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

ASSESS AKI
MODIFIED MINI-MENTAL
STATE EXAM
PHONE VERSION

Participant ID: 1 - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

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





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

ASSESS AKI
MODIFIED MINI-MENTAL
STATE EXAM
PHONE VERSION

Participant ID: 1 - - - - -

Participant Initials: - - - - -

Visit Number: - - - - -

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) ☐₂ Correct
☐₁ 1 or 2 Errors
☐₀ ≥ 3 Errors
☐₀ Can't Do
☐₉₉ 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) ☐₂ Correct
☐₁ 1 or 2 Errors
☐₀ ≥ 3 Errors
☐₀ Can't Do
☐₉₉ Refused

____ (Participant response)
5 4 3 2 1 (Correct order)

8b. Impairment

- ☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

Section Total

____ out of 4





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

ASSESS AKI
MODIFIED MINI-MENTAL
STATE EXAM
PHONE VERSION

Participant ID: 1 - - - - -

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:

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

9b. Number of letters in correct position
RECORD 99 IF PARTICIPANT REFUSED

(1200) - - - letters

9c. Impairment

- ☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

10. Now please spell 'World' backwards.

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

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

10b. Number of letters in correct position
RECORD 99 IF PARTICIPANT REFUSED

(1220) - - - letters

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"/> ₃ Spontaneous recall <input type="checkbox"/> ₂ Correct word/incorrect form <input type="checkbox"/> ₂ After "Something to wear" RECORD: _____ <input type="checkbox"/> ₁ After "Was it shirt, shoes or socks?" (CIRCLE WORD.) <input type="checkbox"/> ₀ 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"/> ₃ Spontaneous recall <input type="checkbox"/> ₂ Correct word/incorrect form <input type="checkbox"/> ₂ After "Was some money" RECORD: _____ <input type="checkbox"/> ₁ After "Was it penny, nickel, or dollar?" (CIRCLE WORD.) <input type="checkbox"/> ₀ 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"/> ₃ Spontaneous recall <input type="checkbox"/> ₂ Correct word/incorrect form <input type="checkbox"/> ₂ After "A good, personal quality" RECORD: _____ <input type="checkbox"/> ₁ After "Was it honesty, charity or modesty?" (CIRCLE WORD.) <input type="checkbox"/> ₀ 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"/> ₃ Correct <input type="checkbox"/> ₁ Missed by 1 year <input type="checkbox"/> ₀ Incorrect <input type="checkbox"/> ₉₉ 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





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

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

12e. What is today's date?

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

Section Total

_____ out of 12





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

ASSESS AKI
MODIFIED MINI-MENTAL
STATE EXAM
PHONE VERSION

Participant ID: 1 - - - - -

Participant Initials: - - - -

Visit Number: - - - -

Visit Date: - - / - - / - - - -

Coordinator ID: - - - - -

12f. What state are you in?

(1390)

☐₂ Correct

☐₀ Incorrect

☐₀ Can't do

☐₉₉ Refused

☐ None

☐ Sight

☐ Hearing

☐ Hands

☐ Other

12g. What country are you in?

(1410)

☐₁ Correct

☐₀ Incorrect

☐₀ Can't do

☐₉₉ Refused

☐ None

☐ Sight

☐ Hearing

☐ Hands

☐ Other

12h. What town are you in?

(1430)

☐₁ Correct

☐₀ Incorrect

☐₀ Can't do

☐₉₉ Refused

☐ None

☐ Sight

☐ Hearing

☐ Hands

☐ Other

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

(1450)

☐₁ Correct

☐₀ Incorrect

☐₀ Can't do

☐₉₉ Refused

☐ None

☐ Sight

☐ Hearing

☐ Hands

☐ 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
MODIFIED MINI-MENTAL
STATE EXAM
PHONE VERSION**

Participant ID: 1 - -

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) ☐₁ Correct (FOREHEAD/BROW)
☐₀ Incorrect
☐₀ Can't do
☐₉₉ Refused

Impairment
☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

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

- (1510) ☐₁ Correct (CHIN)
☐₀ Incorrect
☐₀ Can't do
☐₉₉ Refused

☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

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

- (1530) ☐₁ Correct (SHOULDER)
☐₀ Incorrect
☐₀ Can't do
☐₉₉ Refused

☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

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

- (1550) ☐₁ Correct (ELBOW)
☐₀ Incorrect
☐₀ Can't do
☐₉₉ 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) ☐₁ Correct (KNUCKLES)
☐₀ Incorrect
☐₀ Can't do
☐₉₉ Refused

☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

Section Total

 out of 5





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

ASSESS AKI MODIFIED MINI-MENTAL STATE EXAM PHONE VERSION

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

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)

☐₂ Correct (BODY PART, LIMB, ETC)

☐₁ Partly correct

☐₀ Incorrect

☐₀ Can't do

☐₉₉ Refused

☐ None

☐ Sight

☐ Hearing

☐ Hands

☐ 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



ASSESS AKI MODIFIED MINI-MENTAL STATE EXAM PHONE VERSION

Participant ID: 1 - - - - -

Participant Initials: _____

Visit Number: _____

Visit Date: ____/____/____

Coordinator ID: _____

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

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

TRIAL 1 _____

TRAIL 2

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

TRIAL 1

TRAIL 2

Section Total out of 9



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

Participant ID: 1 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

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

(1710)

- ☐₃ Obeys without prompting
☐₂ Obeys after prompting
☐₁ Says aloud only
☐₀ Incorrect
☐₀ Can't do
☐₉₉ Refused

- ☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

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)

- ☐₁ Taps phone
☐₁ Press/dial number 1
☐₁ Says I'm done
☐₀ No response

- ☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

Total score: ____

- ☐₀ Can't do
☐₉₉ 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)

- ☐₅ Correct sentence
☐₄ Sentence with error(s)
☐₃ Correct sentence after prompt
☐₂ Sentence with error(s) after prompt
☐₁ Incomplete sentence after prompt
☐₀ No response/Can't do
☐₉₉ Refused

- ☐ None
☐ Sight
☐ Hearing
☐ Hands
☐ Other

RECORD SENTENCE: _____

Section Total

____ out of 11



ASSESS AKI MODIFIED MINI-MENTAL STATE EXAM PHONE VERSION

Participant ID: 1 - - - - -

Participant Initials: _____

Visit Number: _____

Visit Date: ____ / ____ / ____

Coordinator ID:

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?
SCORE AS "0" | (1770) | <input type="checkbox"/> ₀ 12
<input type="checkbox"/> ₀ Other (SPECIFY: _____)
<input type="checkbox"/> ₉₉ Refused (SPECIFY: _____) |
| 16aii. What number is the hour hand pointing to? | (1780) | <input type="checkbox"/> ₁ 7
<input type="checkbox"/> ₀ Other (SPECIFY: _____)
<input type="checkbox"/> ₉₉ Refused (SPECIFY: _____) |
| 16aiii. Is the minute hand pointing to the top or the bottom of the clock?
SCORE AS "0" | (1790) | <input type="checkbox"/> ₀ Top
<input type="checkbox"/> ₀ Bottom
<input type="checkbox"/> ₉₉ Refused |
| 16aiv. Is the hour hand pointing to the left or the right side of the clock? | (1800) | <input type="checkbox"/> ₁ Left
<input type="checkbox"/> ₀ Right
<input type="checkbox"/> ₉₉ Refused |
| 16av. Impairment | | <input type="checkbox"/> None
<input type="checkbox"/> Sight
<input type="checkbox"/> Hearing
<input type="checkbox"/> Hands
<input type="checkbox"/> Other |

IF PARTICIPANT MISSES ALL ITEMS IN Q16AI THROUGH Q16AIV, ASSIGN A SCORE OF "0" FOR ITEMSQ16B AND Q16C AND CONTINUE WITH QUESTION 17.

Section Total

(1820) out of 2



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

Participant ID: 1 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

16b. For twenty minutes after eight

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

- (1830) ☐₁ 4
☐₀ Other (SPECIFY: _____)
☐₉₉ Refused (SPECIFY: _____)

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

- (1840) ☐₁ 8
☐₀ Other (SPECIFY: _____)
☐₉₉ Refused (SPECIFY: _____)

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

- (1850) ☐₁ Right
☐₀ Left
☐₉₉ Refused

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

- (1860) ☐₁ Left
☐₀ Right
☐₉₉ Refused

16c. For ten minutes after eleven

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

- (1870) ☐₁ 2
☐₀ Other (SPECIFY: _____)
☐₉₉ Refused (SPECIFY: _____)

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

- (1880) ☐₁ 11
☐₀ Other (SPECIFY: _____)
☐₉₉ Refused (SPECIFY: _____)

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

- (1890) ☐₁ Right
☐₀ Left
☐₉₉ Refused

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

- (1900) ☐₁ Left
☐₀ Right
☐₉₉ Refused

Section Total

(1910) ____ out of 8



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

Participant ID: 1 - -

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"/> ₃ Spontaneous recall	<input type="checkbox"/> None
_____		<input type="checkbox"/> ₂ One of the words was something you wear (RECORD: _____)	<input type="checkbox"/> Sight
		<input type="checkbox"/> ₁ 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"/> ₀ No recall/can't do	<input type="checkbox"/> Other
		<input type="checkbox"/> ₉₉ Refused	
17b. Nickel	(1940)	<input type="checkbox"/> ₃ Spontaneous recall	<input type="checkbox"/> None
_____		<input type="checkbox"/> ₂ One of the words was some money (RECORD: _____)	<input type="checkbox"/> Sight
		<input type="checkbox"/> ₁ 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"/> ₀ No recall/can't do	<input type="checkbox"/> Other
		<input type="checkbox"/> ₉₉ Refused	
17c. Honesty	(1960)	<input type="checkbox"/> ₃ Spontaneous recall	<input type="checkbox"/> None
_____		<input type="checkbox"/> ₂ One of the words was a good personal quality (RECORD: _____)	<input type="checkbox"/> Sight
		<input type="checkbox"/> ₁ 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"/> ₀ No recall/can't do	<input type="checkbox"/> Other
		<input type="checkbox"/> ₉₉ Refused	

Section Total _____ out of 9

Comments:

(6000) : _____





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
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)	____





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
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)	____





ASessment,
Serial **E**valuation, and
Subsequent **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) : _____





ASessment,
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) ☐₁ Yes ☐₀ No

➔ If YES:

2a. Systolic blood pressure > 180

(1020) ☐₁ Yes ☐₀ No

2b. Diastolic blood pressure > 110

(1030) ☐₁ Yes ☐₀ No

3. Was the alert due to acute distress?

(1040) ☐₁ Yes ☐₀ No

➔ If YES:

3a. Chest pain

(1050) ☐₁ Yes ☐₀ No

3b. Severe Respiratory Distress

(1060) ☐₁ Yes ☐₀ No

3c. Acute Neurological Symptoms

(1070) ☐₁ Yes ☐₀ No

3d. Other

(1080) ☐₁ Yes ☐₀ No

➔ If YES: SPECIFY _____

Type of Alert Value(s):

4. Was the alert due to laboratory results?

(1090) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

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

(1110) ☐₁ Yes ☐₀ No

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

(1130) ☐₁ Yes ☐₀ No

4d. Creatinine doubling from last value

(1140) ☐₁ Yes ☐₀ No

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

(1150) ☐₁ Yes ☐₀ No





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: ____

4f. Other abnormal lab value

(1160) ☐₁ Yes ☐₀ No

➔ If YES: SPECIFY _____

5. Was the alert due to ECG results?

(1170) ☐₁ Yes ☐₀ No

➔ If YES:

5a. Date of Reading:

(1180) ____ / ____ / ____
MM DD YYYY

5b. Type of Reading:

(1190) ☐₁ Local ☐₀ Central

5c. Results:

5ci. Bradycardia (<45 beats/min)

(1200) ☐₁ Yes ☐₀ No

5cii. Tachycardia (>120 beats/min)

(1210) ☐₁ Yes ☐₀ No

5ciii. Acute Myocardial Infarction or acute ischemia

(1220) ☐₁ Yes ☐₀ No

5civ. Ventricular Tachycardia/Ventricular Fibrillation

(1230) ☐₁ Yes ☐₀ No

5cv. Atrial Fibrillation

(1240) ☐₁ Yes ☐₀ No

5cvi. Atrial Flutter

(1250) ☐₁ Yes ☐₀ No

5cvii. Mobitz Type II 2nd degree Heart Block

(1260) ☐₁ Yes ☐₀ No

5cviii. 3rd degree Heart Block

(1270) ☐₁ Yes ☐₀ No

5cix. Complete Left Bundle Branch Block

(1280) ☐₁ Yes ☐₀ No

6. Was study site PI notified?

(1290) ☐₁ Yes ☐₀ No

7. What action was taken?

(1300) ☐₁ Primary MD notified
☐₂ Report sent to primary MD
☐₃ Transferred to ER
☐₄ Admitted to hospital
☐₅ No action taken
☐₉₆ Other _____





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

ASSESS AKI
ADULT
ALERT

Participant ID: 1 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

8. Participant notified of outcome?

(1310) ☐₁ Yes ☐₀ No ☐₉₇ N/A

Comments:

(6000) : _____





ASsessment,
Serial Evaluation, and
Subsequent Sequelae in AKI
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) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

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

- 1b. Chest pain (angina, unstable angina, angina pectoris) (1030) ☐₁ Yes ☐₀ No

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

- 1c. Heart failure or fluid in the lungs (congestive heart failure, CHF) (1050) ☐₁ Yes ☐₀ No

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

- 1d. Heart by-pass surgery (coronary artery by-pass surgery, CABG) (1070) ☐₁ Yes ☐₀ No

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

- 1e. Abnormal heart rhythm (heart arrhythmia) (1090) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

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





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

ASSESS AKI
ADULT
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) ☐₁ Yes ☐₀ No

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

1h. Kidney transplant (1150) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

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

1j. Blockage in blood vessels in your neck (carotid artery disease) (1190) ☐₁ Yes ☐₀ No

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

1k. Other medical condition(s) or problem(s) (1210) ☐₁ Yes ☐₀ 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.





ASsessment,
Serial Evaluation, and
Subsequent Sequelae in AKI
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) ☐₁ Yes ☐₀ No

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

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

→ IF YES: Indicate where surgery or angioplasty was performed (1280) ☐₁ Inpatient
☐₂ Outpatient
☐₃ 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) ☐₁ Yes ☐₀ No

→ IF YES: Indicate where angiography was performed (1320) ☐₁ Inpatient
☐₂ Outpatient
☐₃ Both

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

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





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

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) ☐₁ Yes ☐₀ No

➔ IF YES: Indicate where dialysis was performed

(1380) ☐₁ Inpatient
☐₂ Outpatient
☐₃ 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) ☐₁

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.





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

ASSESS AKI
ADULT
MEDICAL EVENT
QUESTIONNAIRE

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
ADULT
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

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 VISIT.

____ / ____ / ____
MM DD YYYY

Smoking History

Since your last ASSESS AKI study visit:

1. Have you smoked any cigarettes? (1000) ☐₁ Yes ☐₀ No
➔ IF NO, PROCEED TO QUESTION 6.
2. Have you smoked more than 100 cigarettes (approximately 5 packs)? (1010) ☐₁ Yes ☐₀ No
3. Do you smoke cigarettes now? (1020) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No
➔ IF NO, PROCEED TO QUESTION 11.
7. Have you smoked at least 20 cigars? (1060) ☐₁ Yes ☐₀ No
8. Do you currently smoke cigars? (1070) ☐₁ Yes ☐₀ 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,
Serial Evaluation, and
Subsequent Sequelae in AKI
NIH/NIDDK

ASSESS AKI
ADULT
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 1 - - - - -

Participant Initials: - - - -

Visit Number: - - -

Visit Date: - - / - - / - - - -

Coordinator ID: - - - - -

11. Since your last ASSESS AKI study visit, have you (1100) ☐₁ Yes ☐₀ No
smoked a tobacco pipe regularly? (HERE
“REGULARLY” MEANS AT LEAST TWO
PIPEFULS OF TOBACCO A WEEK, ALMOST
EVERY WEEK.)
➔ IF NO, PROCEED TO QUESTION 14.
12. Altogether, how many years have you smoked a pipe (1130) - - - . - - years
regularly?
13. How many pipefuls of tobacco do you regularly smoke (1140) - - - pipefuls
per day, on the average?
(IF LESS THAN 1 PER DAY, RECORD 00)
➔ PROCEED TO QUESTION 14.

Alcohol Use History

Since your last ASSESS AKI study visit:

14. Have you had at least one alcoholic drink? (1170) ☐₁ Yes ☐₀ No
➔ IF NO, PROCEED TO QUESTION 19.



FOR QUESTIONS 15 THROUGH 18, AN ALCOHOLIC DRINK CAN BE:



12 ounce can of beer

OR



5 ounce glass of wine

OR



1 shot of liquor

15. How often have you had an alcoholic drink?

(1180)

CHOOSE ONLY ONE RESPONSE.

➔ USE REFERENCE CARD A

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

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

(1190)

➔ USE REFERENCE CARD B

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





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

ASSESS AKI
ADULT
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 1 - - - - -

Participant Initials: - - - -

Visit Number: - - -

Visit Date: - - / - - / - - - -

Coordinator ID: - - - - -



12 ounce can of beer OR



5 ounce glass of wine OR



1 shot of liquor

17. What was the largest number of alcoholic drinks that you had in a 24-hour period? (1200)
→ USE REFERENCE CARD B

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

18. Since your last ASSESS AKI study visit:

(1210)

- 18a. **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

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





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

ASSESS AKI
ADULT
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 1 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

- 18b. **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

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

Recreational Drug Use History

Since your last ASSESS AKI study visit:

19. Have you used marijuana?

(1230)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

- 19a. IF **YES**: Have you used marijuana within the past 30 days?

(1240)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

20. Have you used methamphetamines?

(1250)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

- 20a. IF **YES**: Have you used them within the past 30 days?

(1260)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer





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

ASSESS AKI
ADULT
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 1 - - - - -

Participant Initials: - - - -

Visit Number: - - -

Visit Date: - - / - - / - - - -

Coordinator ID: - - - - -

21. Have you used cocaine?

(1270)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

21a. IF **YES**: Have you used cocaine within the past
30 days?

(1280)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

22. Have you used heroin?

(1290)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

22a. IF **YES**: Have you used heroin within the past
30 days?

(1300)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

23. Have you used other street drugs?
SPECIFY: _____

(1310)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

23a. IF **YES**: Have you used other street drugs within
the past 30 days?

(1320)

- ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

Health Insurance

24. Since your last ASSESS AKI study visit, have any
changes occurred in your healthcare coverage?

(1330)

- ☐₁ Yes ☐₀ No

➔ IF **NO**, PROCEED TO QUESTION 29.





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

ASSESS AKI
ADULT
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 1 - - - - -

Participant Initials: - - - - -

Visit Number: - - - - -

Visit Date: - - - / - - - / - - - - -

Coordinator ID: - - - - -

25. (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

- | | | | |
|---------------------------------|--------|---|--|
| 25a. Uninsured | (1340) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25b. Self-insured | (1350) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25c. COBRA | (1360) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25d. Commercial/fee-for-service | (1370) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25e. HMO | (1380) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25f. Local/state insurance | (1390) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25g. Military | (1400) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25h. Medicare | (1410) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25i. Medicaid | (1420) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25j. Self-pay | (1430) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 25k. Other _____ | (1440) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |

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

- | | | | |
|---|--------|---|--|
| 26a. Provincial/Public Health Insurance | (1450) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26b. Private/Personal insurance | (1460) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |





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

ASSESS AKI
ADULT
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 1 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

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

For Research Coordinator use only:

- Where was CRF completed? (1520) ☐₁ At home
☐₂ In-clinic
☐₃ On the phone
- Who completed the CRF? (1530) ☐₁ Participant completed
☐₂ Interviewer completed
- IF **PARTICIPANT COMPLETED**: Did Research Coordinator review the CRF with the participant during the in-person visit? (1540) ☐₁ Yes ☐₀ No
- IF **YES**: Signature of Research Coordinator (1550) _____
- IF **YES**: Date Signature Completed (1560) ____ / ____ / ____
MM DD YYYY

Comments:

(6000): _____





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

ASSESS AKI ADULT MEDICAL 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

➔ IF NO, PROCEED TO QUESTION 2.

- 1a. Did you receive chemotherapy?

(1010) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

➔ IF YES: Did you receive?

- 1ai. cisplatin

(1020) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 1aai. ifosfamide

(1030) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 1aiii. methotrexate

(1040) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 1aiv. gemcitabine (gemzar)

(1050) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 1av. bevacizumab (avastin)

(1060) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 2b. Chronic obstructive pulmonary disease
(emphysema or chronic bronchitis)

(1080) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 2c. Hepatitis (B or C) infection

(1090) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 2d. Rheumatoid arthritis

(1100) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 2e. Gout

(1110) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

- 2f. Systemic lupus

(1120) ☐₁ Yes ☐₀ No ☐₉₈ Don't know





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

ASSESS AKI ADULT MEDICAL 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) ☐₁ Yes ☐₀ No

→ IF **NO**, PROCEED TO QUESTION 4.

3a. Are you currently pregnant? (1140) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

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

→ IF **YES**: record the date.

(1170) ____ month
MM

(1172) ____ year
YYYY

4b. Did you have a hysterectomy? (1175) ☐₁ Yes ☐₀ No

Renal History

Since your last ASSESS AKI visit:

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





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

ASSESS AKI ADULT MEDICAL HISTORY

Participant ID: 1 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

8. Was your kidney function measured by a 24-hour urine test or I-iothalamate clearance test? (1210) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
9. Did you have a kidney xray (KUB)? (1220) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
10. Did you have any vaccinations to lower your risk of infection? (1230) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 10a. IF **YES**: did you have one or more vaccines to prevent bacterial infection? (e.g. pneumovax) (1240) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 10b. IF **YES**: did you have a flu vaccine? (1250) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ months
☐₂ weeks
☐₃ days
☐₉₇ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 12a. IF **YES**: do you currently take prescribed medication for your hypertension or high blood pressure? (1290) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ months
☐₂ weeks
☐₃ days
☐₉₇ N/A





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

ASSESS AKI ADULT MEDICAL HISTORY

Participant ID: 1 - - - - -

Participant Initials: - - - -

Visit Number: - - - -

Visit Date: - - / - - / - - - -

Coordinator ID: - - - - -

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

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

Diabetic History

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

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

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

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





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

ASSESS AKI ADULT MEDICAL HISTORY

Participant ID: 1 - - - - -

Participant Initials: - - - - -

Visit Number: - - - - -

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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

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

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

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

For Research Coordinator use only:

Where was the CRF completed? (1450) ☐₁ At home
☐₂ In-clinic
☐₃ On the phone

Who completed the CRF? (1460) ☐₁ Participant completed
☐₂ Interviewer completed

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

IF **YES**: Signature of Research Coordinator

(1480) _____

IF **YES**: Date Signature Completed

(1490) ____ / ____ / ____
MM DD YYYY

Comments:

(6000) : _____





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

ASSESS AKI
ADULT
OUTPATIENT YEARLY
SPECIMEN COLLECTION:
BLOOD

Participant ID: 1 - - - - -

Participant Initials: - - - - -

Visit Number: - - - - -

Visit Date: - - - / - - - / - - - - -

Coordinator ID: - - - - -

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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. Were the following vacutainers collected?

Priority Order	Specimen type	Vacutainer volume	
1	Serum (red)	9 mL SST or 7.5 mL double SST	(1030) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
2	Serum (red)	9 mL SST or 7.5 mL double SST	(1040) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
3	EDTA (purple)	3 mL to LOCAL LAB	(1050) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
4	EDTA (purple)	10 mL for PLASMA	(1060) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
5	EDTA (purple)	10 mL for PLASMA	(1070) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
6	Citrate (blue)	4.5 mL	(1080) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
<p>➔ IF NO TO ANY OF THE ABOVE (Q1030 – Q1080), RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THIS COLLECTION AND COMPLETE THE OUTPATIENT SPECIMEN 2+ COLLECTION: BLOOD (P1_OUTPT_COLLECT_BLD_2) FORM.</p> <p>➔ IF NO TO ANY OF THE ABOVE (Q1030 – Q1080), AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER OUTPATIENT VISIT WITHIN THE VISIT WINDOW.</p>			

➔ COMPLETE THE SITE SPECIFIC WORKSHEET.

Comments:

(6000) : - - - - -





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

ASSESS AKI
ADULT
OUTPATIENT YEARLY
SPECIMEN 2+
COLLECTION:BLOOD

Participant ID: 1 - - - - -

Participant Initials: - - - - -

Visit Number: - - - - -

Visit Date: - - - / - - - / - - - - -

Coordinator ID: - - - - -

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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. Were the following vacutainers collected?

Priority Order	Specimen type	Vacutainer volume	
1	Serum (red)	9 mL SST or 7.5 mL double SST	(1030) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
2	Serum (red)	9 mL SST or 7.5 mL double SST	(1040) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
3	EDTA (purple)	3 mL to LOCAL LAB	(1050) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
4	EDTA (purple)	10 mL for PLASMA	(1060) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
5	EDTA (purple)	10 mL for PLASMA	(1070) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
6	Citrate (blue)	4.5 mL	(1080) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
<p>→ IF NO TO ANY OF THE ABOVE (Q1030 – Q1080), RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THE INITIAL COLLECTION.</p> <p>→ IF NO TO ANY OF THE ABOVE (Q1030 – Q1080), AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER OUTPATIENT VISIT WITHIN THE VISIT WINDOW.</p>			

→ COMPLETE THE SITE SPECIFIC WORKSHEET.

Comments:

(6000) : _____





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

ASSESS AKI
ADULT
OUTPATIENT YEARLY
SPECIMEN COLLECTION:
URINE

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

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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. Was a urine sample collected at this visit? (1040) ☐₁ Yes ☐₀ No

➔ **IF NO**, RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THIS COLLECTION AND COMPLETE THE OUTPATIENT SPECIMEN 2+ COLLECTION: URINE (P1_OUTPT_COLLECT_UA_2) FORM.

➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER OUTPATIENT VISIT WITHIN THE VISIT WINDOW.

➔ COMPLETE THE SITE SPECIFIC WORKSHEET.

Comments:

(6000) : _____





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

ASSESS AKI
ADULT
OUTPATIENT YEARLY
SPECIMEN 2+
COLLECTION: URINE

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

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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. Was a urine sample collected at this visit? (1040) ☐₁ Yes ☐₀ 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 OUTPATIENT VISIT WITHIN THE VISIT WINDOW.

- ➔ COMPLETE THE SITE SPECIFIC WORKSHEET

Comments:

(6000) : _____





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

ASSESS AKI
ADULT
OUTPATIENT YEARLY
SPECIMEN PROCESSING

Participant ID: 1 - ____ - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

Blood Specimen Processing

1. Are there any blood samples to be processed? (1000) ☐₁ Yes ☐₀ No
➔ IF **NO**, COMPLETE SITE SPECIFIC WORKSHEET
AND PROCEED TO QUESTION 7.
2. How many 1.0 mL aliquots of serum were produced from 9 mL SST or 7.5 mL double SST red top vacutainers? (1010) ____ aliquots
(ASSESS-AKI goal 6 X 1.0 mL)
 - 2a. If greater than 6 aliquots, estimate the volume of additional serum saved. (1020) ____ mL
(REPORT TO THE NEAREST ML. IF Q1010=6 AND NO ADDITIONAL SERUM SAVED, RECORD 0 IN Q1020.)
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. (1040) ____ mL
(REPORT TO THE NEAREST ML. IF Q1030=5 AND NO ADDITIONAL PLASMA SAVED, RECORD 0 IN Q1040.)
4. 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
 - 4a. 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.)
5. Date samples frozen (1070) ____ / ____ / ____
MM DD YYYY
6. Time samples frozen (1080) ____
(Aliquots should be stored in a -80 freezer)





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

ASSESS AKI
ADULT
OUTPATIENT YEARLY
SPECIMEN PROCESSING

Participant ID: 1 - ____ - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

Urine Specimen Processing

7. Are there any urine samples to be processed?
➔ IF **NO**, COMPLETE SITE SPECIFIC WORKSHEET
AND PROCEED TO BIOLOGICAL SAMPLE
TRACKING MODULE.

(1090) ☐₁ Yes ☐₀ No

8. How many 1.0 mL aliquots of urine were produced?
(ASSESS-AKI goal 10 X 1.0 mL)

(1100) ____ aliquots

9. How many 10 mL aliquots of urine were produced?
(ASSESS-AKI goal – 4 X 10 mL at V12M, V24M, V36M)

(1110) ____ aliquots

10. Date samples frozen

(1120) ____ / ____ / ____
MM DD YYYY

11. Time samples frozen
(Aliquots should be stored in a -80 freezer)

(1130) ____

Comments:

(6000) : _____





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

ASSESS AKI
ADULT
OUTPATIENT YEARLY
SPECIMEN PROCESSING
2+

Participant ID: 1 - ____ - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

1. Date of collection:

(995) ____ / ____ / ____
MM DD YYYY

Blood Specimen Processing

2. Are there any blood samples to be processed?
➔ IF **NO**, COMPLETE SITE SPECIFIC WORKSHEET
AND PROCEED TO QUESTION 8.

(1000) ☐₁ Yes ☐₀ No

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 6 X 1.0 mL)

(1010) ____ aliquots

3a. If greater than 6 aliquots, estimate the volume of
additional serum saved.
(REPORT TO THE NEAREST ML. IF Q1010=6 AND
NO ADDITIONAL SERUM SAVED, RECORD 0 IN
Q1020.)

(1020) ____ mL

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.
(REPORT TO THE NEAREST ML. IF Q1030=5 AND
NO ADDITIONAL PLASMA SAVED, RECORD 0 IN
Q1040.)

(1040) ____ mL

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
(Aliquots should be stored in a -80 freezer)

(1080) ____





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

ASSESS AKI
ADULT
OUTPATIENT YEARLY
SPECIMEN PROCESSING
2+

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

Urine Specimen Processing

8. Are there any urine samples to be processed? (1090) ☐₁ Yes ☐₀ 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 – 4 X 10 mL at V12M, V24M, V36M)
11. Date samples frozen (1120) - - - / - - - / - - - - -
MM DD YYYY
12. Time samples frozen (1130) - - - - -
(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) : _____





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
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
(> 99th percentile plus 5 mmHg)?

(1010) ☐₁ Yes ☐₀ No

➔ REFER TO HEIGHT AND GENDER BASED
BLOOD PRESSURE NORMS CHART.

3. Was the alert due to hypotension?

(1020) ☐₁ Yes ☐₀ No

➔ If YES:

3a. Systolic blood pressure < 60 for infants

(1030) ☐₁ Yes ☐₀ No ☐₉₇
N/A

3b. Systolic blood pressure < 70 for children older
than one year.

(1040) ☐₁ Yes ☐₀ No ☐₉₇
N/A

4. Was the alert due to acute distress?

(1050) ☐₁ Yes ☐₀ No

➔ If YES:

4a. Chest pain

(1060) ☐₁ Yes ☐₀ No

4b. Severe Respiratory Distress

(1070) ☐₁ Yes ☐₀ No

4c. Acute Neurological Symptoms

(1080) ☐₁ Yes ☐₀ No

4d. Other

(1090) ☐₁ Yes ☐₀ No

➔ If YES: SPECIFY _____

Type of Alert Value(s):

5. Was the alert due to laboratory results?

(1100) ☐₁ Yes ☐₀ No

➔ If YES:

5a. Creatinine doubling from last value

(1140) ☐₁ Yes ☐₀ No

5b. Other abnormal lab value

(1160) ☐₁ Yes ☐₀ No

➔ If YES: SPECIFY _____

6. Was study site PI notified?

(1170) ☐₁ Yes ☐₀ No





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

ASSESS AKI PEDIATRIC ALERT

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

7. What action was taken?

- (1180) ☐₁ Primary MD notified
☐₂ Report sent to primary MD
☐₃ Transferred to ER
☐₄ Admitted to hospital
☐₅ No action taken
☐₉₆ Other _____

8. Participant/Participant's guardian notified of outcome?

- (1190) ☐₁ Yes ☐₀ No ☐₉₇
N/A

Comments:

(6000) : _____





ASsessment,
Serial Evaluation, and
Subsequent Sequelae in AKI
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) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

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

- 1b. Abnormal heart rhythm (1030) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

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

- 1d. Kidney transplant (1070) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

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

- 1f. Other medical condition(s) or problem(s) (1110) ☐₁ Yes ☐₀ No

1fi. IF **YES**: Number of ER Visits/Hospitalizations (1120) ____





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

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) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No
- 3b. Fontan surgery (1170) ☐₁ Yes ☐₀ No
- 3c. Conduit replacement (1180) ☐₁ Yes ☐₀ No
- 3d. Mitral valve repair/replacement (1190) ☐₁ Yes ☐₀ No
- 3e. Aortic valve repair/replacement (1200) ☐₁ Yes ☐₀ No
- 3f. Other (1210) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No
- 4c. Did you/your child have sepsis (severe infection)? (1250) ☐₁ Yes ☐₀ No
- 4d. Were you/your child in the intensive care unit for a repeat heart surgery? (1260) ☐₁ Yes ☐₀ No





ASsessment,
Serial Evaluation, and
Subsequent Sequelae in AKI
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) ☐₁ Yes ☐₀ No

➔ IF **YES**: Indicate where angiography was performed

(1290) ☐₁ Inpatient
☐₂ Outpatient
☐₃ 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) ☐₁ Yes ☐₀ No

➔ IF **YES**: Indicate where dialysis was performed

(1330) ☐₁ Inpatient
☐₂ Outpatient
☐₃ 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





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

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 VISIT.

____ / ____ / ____
MM DD YYYY

1. Are you/your child currently in school or home-schooled? (1000) ☐₁ Yes ☐₀ No

→ IF **NO**: Please explain:

- 1a. IF **YES**: What grade are you/your child in? (1010) ____
(IF BETWEEN GRADES, ENTER LAST
GRADE COMPLETED)

- 1b. IF **YES**: Are you/your child receiving any form of special education? (1020) ☐₁ Yes ☐₀ No

→ IF **YES**: Please specify:

- 1c. IF **YES**: Did you/your child pass the last school year? (1030) ☐₁ Yes ☐₀ No

→ IF THE PARTICIPANT IS **LESS THAN 12 YEARS OF AGE**, PROCEED TO QUESTION 25.

Smoking History

Since your/your child's last ASSESS AKI study visit:

2. Have you/your child smoked any cigarettes? (1040) ☐₁ Yes ☐₀ 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) ☐₀ 0 ☐₁ 1 ☐₂ >1

- 3a. IF >1: Indicate the number of days: (1060) ____





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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

4. Have you/your child smoked more than 100 cigarettes (approximately 5 packs)? (1070) ☐₁ Yes ☐₀ No
5. Do you/your child smoke cigarettes now? (1080) ☐₁ Yes ☐₀ 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? (1100) ____ months
ENTER 98 IF THE PARTICIPANT DOESN'T KNOW.
8. Have you/your child smoked cigars? (1110) ☐₁ Yes ☐₀ No
➔ IF NO, PROCEED TO QUESTION 13.
9. Have you/your child smoked at least 20 cigars? (1120) ☐₁ Yes ☐₀ No
10. Do you/your child currently smoke cigars? (1130) ☐₁ Yes ☐₀ 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? (1150) ____ months
ENTER 98 IF THE PARTICIPANT DOESN'T KNOW.
13. Since your/your child's last ASSESS AKI study visit, have you/your child smoked a tobacco pipe regularly? (1160) ☐₁ Yes ☐₀ No
(HERE "REGULARLY" MEANS AT LEAST TWO PIPEFULS OF TOBACCO A WEEK, ALMOST EVERY WEEK.)
➔ IF NO, PROCEED TO QUESTION 16.
14. Altogether, how many years have you/your child smoked a pipe regularly? (1190) ____ . ____ years





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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 2 - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

15. How many pipefuls of tobacco do you/your child regularly smoke per day, on the average?
(IF LESS THAN 1 PER DAY, RECORD 00)
➔ PROCEED TO QUESTION 16.
- (1200) ____ pipefuls

Alcohol Use History

Since your/your child's last ASSESS AKI study visit:

16. Have you/your child had at least one alcoholic drink?
➔ IF **NO**, PROCEED TO QUESTION 20.
- (1230) ☐₁ Yes ☐₀ No

FOR QUESTIONS 17 THROUGH 19, AN ALCOHOLIC DRINK CAN BE:



12 ounce can of beer

OR



5 ounce glass of wine

OR



1 shot of liquor

17. How often have you/your child had an alcoholic drink?
CHOOSE ONLY ONE RESPONSE.
➔ USE REFERENCE CARD A
- (1240)
- ☐₁ Every day
 - ☐₂ 5 to 6 times a week
 - ☐₃ 3 to 4 times a week
 - ☐₄ 2 times a week
 - ☐₅ 1 time a week
 - ☐₆ 2 to 3 times a month
 - ☐₇ 1 time a month
 - ☐₈ 3 to 11 times since your last clinic visit
 - ☐₉ 1 or 2 times since your last clinic visit
 - ☐₉₉ Don't wish to answer





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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____



12 ounce can of beer

OR



5 ounce glass of wine

OR



1 shot of liquor

18. On the days you/your child drank, how many alcoholic drinks did you/your child usually have?

→ USE REFERENCE CARD B

(1250)

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

19. What was the largest number of alcoholic drinks that you/your child had in a 24-hour period?

→ USE REFERENCE CARD B

(1260)

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





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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

Recreational Drug Use History

Since your/your child's last ASSESS AKI study visit:

20. Have you/your child used marijuana? (1270) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer
- 20a. IF **YES**: Have you/your child used marijuana within the past 30 days? (1280) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer
21. Have you/your child used methamphetamines? (1290) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer
- 21a. IF **YES**: Have you/your child use them within the past 30 days? (1300) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer
22. Have you/your child used cocaine? (1310) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer
- 22a. IF **YES**: Have you/your child used cocaine within the past 30 days? (1320) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer





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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 2 - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

23. Have you/your child used heroin? (1330) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer
- 23a. IF **YES**: Have you/your child used heroin within the past 30 days? (1340) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer
24. Have you/your child used other street drugs? SPECIFY: _____ (1350) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer
- 24a. IF **YES**: Have you/your child used other street drugs within the past 30 days? (1360) ☐₁ Yes
☐₀ No
☐₉₈ Don't know
☐₉₉ Don't wish to answer

Health Insurance

25. Since your/your child's last ASSESS AKI study visit, have any changes occurred in your/your child's healthcare coverage? (1370) ☐₁ Yes ☐₀ No
➔ IF **NO**, PROCEED TO QUESTION 30.





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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

26. (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

- | | | | |
|---------------------------------|--------|---|--|
| 26a. Uninsured | (1380) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26b. Self-insured | (1390) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26c. COBRA | (1400) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26d. Commercial/fee-for-service | (1410) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26e. HMO | (1420) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26f. Local/state insurance | (1430) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26g. Military | (1440) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26h. Medicare | (1450) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26i. Medicaid | (1460) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26j. Self-pay | (1470) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 26k. Other _____ | (1480) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |

27. (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.

- | | | | |
|---|--------|---|--|
| 27a. Provincial/Public Health Insurance | (1490) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| 27b. Private/Personal insurance | (1500) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |





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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

28. Since your/your child's last ASSESS AKI study visit, was there ever a time when you were not covered by health insurance? (1510) ☐₁ Yes ☐₀ No
- IF **YES**: were you/your child not covered by health insurance for one month or more? (1520) ☐₁ Yes ☐₀ No
29. Since your/your child's last ASSESS AKI study visit, were you/your child denied health insurance? (1530) ☐₁ Yes ☐₀ No
30. Since your/your child's last ASSESS AKI study visit, were you/your child unable to fill a prescription because of the cost? (1540) ☐₁ Yes ☐₀ No
31. 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) ☐₁ Yes ☐₀ No

For Research Coordinator use only:

Where was the CRF completed? (1560) ☐₁ At home
☐₂ In-clinic
☐₃ On the phone

Who completed the CRF? (1570) ☐₁ Participant completed
☐₂ Interviewer completed
☐₃ Guardian completed

IF **PARTICIPANT OR GUARDIAN COMPLETED**: (1580) ☐₁ Yes ☐₀ 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





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

ASSESS AKI
PEDIATRIC
LIFESTYLE
YEARLY VISITS
(V12M, V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

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 MEDICAL HISTORY

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 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- ➔ IF **NO**, PROCEED TO QUESTION 2.
- 1a. Did you/your child receive chemotherapy? (1010) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- ➔ IF **YES**: Did you/your child receive?
- 1ai. cisplatin (1020) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 1aii. ifosfamide (1030) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 1aiii. methotrexate (1040) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 1av. carboplatin (1050) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 2b. Chronic obstructive pulmonary disease (cystic fibrosis, bronchiolitis) (1070) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 2c. Hepatitis (B or C) infection (1080) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 2d. Liver disease (1090) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 2e. Genetic syndrome (1100) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 2ei. If **YES**, Down's/Trisomy 21 (1110) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 2eii. If **YES**, DiGeorge/ 22q11 deletion (1120) ☐₁ Yes ☐₀ No ☐₉₈ Don't know



**ASSESS AKI
PEDIATRIC
MEDICAL
HISTORY**

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

2eiii. If **YES**, Turner syndrome (1130) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2eiv. If **YES**, Williams syndrome (1140) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2ev. If **YES**, VACTERL association (1150) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2evi. If **YES**, CHARGE syndrome (1160) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2evii. If **YES**, Undefined genetic syndrome (1170) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2eviii. If **YES**, Other (1180) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

➔ IF **YES**: SPECIFY

2f. Neurological/developmental disease (1190) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fi. If **YES**, Seizure disorder (1200) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fii. If **YES**, Hydrocephalus (1210) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fiii. If **YES**, Autism/autism spectrum disorder (1220) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fiv. If **YES**, ADD/ADHD (1230) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fv. If **YES**, Muscular dystrophy (1240) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fvi. If **YES**, Cerebral palsy (1250) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fvii. If **YES**, Spina bifida (1260) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fviii. If **YES**, Requires a wheelchair (1270) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2fvix. Other (1280) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

➔ IF **YES**: SPECIFY:

2g. Rheumatoid arthritis (1290) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2h. Gout (1300) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

2i. Systemic lupus (1310) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

➔ IF PARTICIPANT IS **MALE**, PROCEED TO QUESTION 7.





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: ____

Women's Health History

Since your last ASSESS AKI visit:

3. Were you/your child pregnant in the time period? (1320) ☐₁ Yes ☐₀ No
➔ IF **NO**, PROCEED TO QUESTION 4.

3a. Are you/your child currently pregnant? (1330) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No

6. Do you/your child know when you/your child's last menstrual period started? (1370) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

➔ IF YOU ANSWERED **NO** TO BOTH QUESTIONS 7 AND 8, PROCEED TO QUESTION 15.





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: ____

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) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 9ai. Hydronephrosis (dilated kidney system) | (1420) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 9aii. Vesico-ureteral reflux (reflux) | (1430) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 9aiii. Single kidney | (1440) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 9aiv. Horseshoe kidney | (1450) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 9av. Small kidneys | (1460) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 9avi. Dysplasia | (1470) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 9avii. Polycystic kidney disease | (1480) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 9aviii. Family history of kidney disease | (1490) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ 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) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 11. Was your/your child's kidney function measured by a 24-hour urine test or I-iothalamate clearance test? | (1510) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 12. Did you/your child have a kidney xray (KUB)? | (1520) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 13. Was your/your child's kidney function checked with a blood test? | (1530) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 14. Have you/your child had any red, pink, or brown colored urine? | (1540) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |
| 15. Did you/your child have any vaccinations to lower your/your child's risk of infection? | (1550) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉₈ Don't know |





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: ____

15a. IF **YES**: did you/your child have one or more vaccines to prevent bacterial infection? (e.g. pneumovax) (1560) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

15b. IF **YES**: did you/your child have a flu vaccine? (1570) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

15c. IF **YES**: did you/your child have the RSV vaccine? (1580) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ months
☐₂ weeks
☐₃ days
☐₉₇ 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) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

Diabetic History

18. Have you/your child ever been told that you/your child have diabetes or high blood sugar? (1635) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

20. Are you/your child currently taking insulin? (1650) ☐₁ Yes ☐₀ No ☐₉₈ Don't know





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: ____

20a. Are you/your child currently taking injectable drugs, other than insulin, to manage your/your child's blood sugar? (1660) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

21. Since your last ASSESS AKI visit, did you/your child have your eyes examined by a doctor? (1680) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

23b. Loss of sensation in your/your child's hands or feet (1720) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

23c. Decreased ability to feel the hotness or coldness of things you/your child touch (1730) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

23d. Sores or ulcers on your/your child's feet or ankles (1740) ☐₁ Yes ☐₀ No ☐₉₈ 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) ☐₁ Yes ☐₀ No

24a. If **YES**, Failure to thrive (1760) ☐₁ Yes ☐₀ No ☐₉₈ Don't know





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

ASSESS AKI PEDIATRIC MEDICAL HISTORY

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

- 24b. If **YES**, Weight is too low for age and gender (1770) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 24c. If **YES**, Height is too low for age and gender (1780) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 24d. If **YES**, Both weight and height too low for age and gender (1790) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
25. Do you/your child have concerns about you/your child's growth? (1800) ☐₁ Yes ☐₀ No
26. Do you/your child receive nutrition through a nasogastric or gastrostomy tube? (1810) ☐₁ Yes ☐₀ No
27. Do you/your child have any nutritional restrictions for medical reasons? (1820) ☐₁ Yes ☐₀ No
- 27a. If **YES**, Celiac disease (1830) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 27b. If **YES**, Inflammatory bowel disease (1840) ☐₁ Yes ☐₀ No ☐₉₈ Don't know
- 27c. If **YES**, Other malabsorption problem (e.g., short bowel) (1850) ☐₁ Yes ☐₀ No ☐₉₈ Don't know

For Research Coordinator use only:

Where was the CRF completed?

- (1860) ☐₁ At home
☐₂ In-clinic
☐₃ On the phone

Who completed the CRF?

- (1870) ☐₁ Participant completed
☐₂ Interviewer completed
☐₃ Guardian completed

IF PARTICIPANT OR GUARDIAN COMPLETED:
Did Research Coordinator review the CRF with the participant/guardian during the in-person visit?

- (1880) ☐₁ Yes ☐₀ No

IF YES: Signature of Research Coordinator

(1890) _____

IF YES: Date Signature Completed

(1900) ____ / ____ / ____
MM DD YYYY





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae 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
SPECIMEN COLLECTION:
BLOOD
(V24M, V36M, V48M, V60M,
V72M, V84M, V96M)

Participant ID: 2 - - - - -

Participant Initials: - - - -

Visit Number: - - - -

Visit Date: - - / - - / - - - -

Coordinator ID: - - - - -

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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 plasma sample collected? (1030) ☐₁ Yes ☐₀ No

- ➔ IF NO, RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THIS COLLECTION AND COMPLETE THE PEDIATRIC OUTPATIENT SPECIMEN 2+ COLLECTION: BLOOD (P2_OUTPT_COLLECT_BLD_2) FORM.
- ➔ IF NO, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER VISIT WITHIN THE VISIT WINDOW.
- ➔ IF NO, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE.

5. (COMPLETE ONLY IF BLOOD WAS COLLECTED) How was blood collected? (1040) ☐₁ Venipuncture
☐₂ Capillary

6. Was the following vacutainer collected?

Priority Order	Specimen type	
1	EDTA (purple)	(1050) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No

- ➔ COMPLETE THE SITE SPECIFIC WORKSHEET.

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT
SPECIMEN 2+
COLLECTION: BLOOD
(V24M, V36M, V48M, V60M,
V72M, V84M)

Participant ID: 2 - - - - -

Participant Initials: - - - - -

Visit Number: - - - - -

Visit Date: - - - / - - - / - - - - -

Coordinator ID: - - - - -

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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 plasma sample collected after the initial collection? (1030) ☐₁ Yes ☐₀ 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 VISIT WITHIN THE VISIT WINDOW.

→ IF NO, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE.

5. (COMPLETE ONLY IF BLOOD WAS COLLECTED) How was the blood collected? (1040) ☐₁ Venipuncture
☐₂ Capillary

6. Was the following vacutainer collected?

Priority order	Specimen type	
1	EDTA (purple)	(1050) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No

→ COMPLETE THE SITE SPECIFIC WORKSHEET.

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT
SPECIMEN COLLECTION:
URINE
(V24M, V36M, V48M, V60M,
V72M, V84M, V96M)

Participant ID: 2 - ____ - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No
5. How was the urine sample collected? (1040) ☐₁ Midstream
☐₂ Cotton ball
☐₃ Bag
6. Was a urine sample collected at this visit? (1050) ☐₁ Yes ☐₀ No

➔ **IF NO**, RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THIS COLLECTION AND COMPLETE THE PEDIATRIC OUTPATIENT SPECIMEN 2+ COLLECTION: URINE (P2_OUTPT_COLLECT_UA_2) FORM.

➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER OUTPATIENT VISIT WITHIN THE VISIT WINDOW.

➔ COMPLETE THE SITE SPECIFIC WORKSHEET.

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT
SPECIMEN 2+
COLLECTION: URINE
(V24M, V36M, V48M, V60M,
V72M, V84M)

Participant ID: 2 - ____ - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No
5. How was the urine collected? (1040) ☐₁ Midstream
☐₂ Cotton ball
☐₃ Bag
6. Was a urine sample collected after the initial collection? (1050) ☐₁ Yes ☐₀ 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 OUTPATIENT VISIT WITHIN THE VISIT WINDOW.
- ➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER OUTPATIENT VISIT CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE.

➔ COMPLETE THE SITE SPECIFIC WORKSHEET

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT
SPECIMEN PROCESSING
(V24M, V36M, V48M,
V60M, V72M, V84M, V96M)

Participant ID: 2 - ____ - ____
Participant Initials: ____
Visit Number: ____
Visit Date: ____ / ____ / ____
Coordinator ID: ____

Blood Specimen Processing

1. Are there any blood samples to be processed? (1000) ☐₁ Yes ☐₀ 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? (1030) ☐₁ Yes ☐₀ No
4a. If YES, estimate volume of additional plasma saved. (1040) ____ . ____ mL
5. Date samples frozen (1050) ____ / ____ / ____
MM DD YYYY
6. Time samples frozen (1060) ____
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? (1070) ☐₁ Yes ☐₀ 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? (1080) ____ aliquots
(ASSESS-AKI goal – 10 X 1.0 mL)
9. How many 10 mL aliquots of urine were produced? (1090) ____ aliquots
(ASSESS-AKI goal – 1 X 10 mL)
10. Date samples frozen (1100) ____ / ____ / ____
MM DD YYYY
11. Time samples frozen (1110) ____
RECORD TIME USING A 24-HOUR CLOCK.
(Aliquots should be stored in a -80 freezer)

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT
SPECIMEN PROCESSING
2+
(V24M, V36M, V48M,
V60M, V72M, V84M)

Participant ID: 2 - ____ - ____
Participant Initials: ____
Visit Number: ____
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) ☐₁ Yes ☐₀ No
➔ IF NO, COMPLETE THE SITE SPECIFIC WORKSHEET
AND PROCEED TO QUESTION 8.
3. How many 0.5 mL aliquots were produced? (1010) ____ aliquots
(ASSESS-AKI goal 1 X 0.5 mL)
4. How many 0.25 mL aliquots were produced? (1020) ____ aliquots
(ASSESS-AKI goal 4 X 0.25 mL)
5. Is there an extra aliquot? (1030) ☐₁ Yes ☐₀ No
- 4a. If YES, estimate volume of additional plasma saved. (1040) ____ . ____ mL
6. Date samples frozen (1050) ____ / ____ / ____
MM DD YYYY
7. Time samples frozen (1060) ____
(RECORD TIME USING A 24-HOUR CLOCK)
(Aliquots should be stored in a -80 freezer)

Urine Specimen Processing

8. Are there any urine samples to be processed? (1070) ☐₁ Yes ☐₀ 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? (1080) ____ aliquots
(ASSESS-AKI goal 10 X 1.0 mL)
10. How many 10 mL aliquots of urine were produced? (1090) ____ aliquots
(ASSESS-AKI goal – 1 X 10 mL)
11. Date samples frozen (1100) ____ / ____ / ____
MM DD YYYY
12. Time samples frozen (1110) ____
(RECORD TIME USING A 24-HOUR CLOCK)
(Aliquots should be stored in a -80 freezer)





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

ASSESS AKI
PEDIATRIC
OUTPATIENT
SPECIMEN PROCESSING
2+
(V24M, V36M, V48M,
V60M, V72M, V84M)

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: ____

Visit Date: ____ / ____ / ____

Coordinator ID: ____

➔ 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
Subsequent Sequelae in AKI
NIH/NIDDK

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN COLLECTION:
BLOOD

Participant ID: 2 - - - -

Participant Initials:

Visit Number: 1 2 M

Visit Date: / / - - -

Coordinator ID:

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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 (0.175 ml) of plasma collected? (1030) ☐₁ Yes ☐₀ No

- **IF NO**, RESCHEDULE ANOTHER COLLECTION WITHIN 48 HOURS OF THIS COLLECTION AND COMPLETE THE PEDIATRIC OUTPATIENT V12M SPECIMEN 2+ COLLECTION: BLOOD (P2_V12M_COLLECT_BLD_2) FORM.
- **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER V12M WITHIN THE VISIT WINDOW.
- **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT 12M CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE AND COMPLETE THE ASSESS-AKI WITHDRAWAL (WITHDR) FORM

5. (COMPLETE ONLY IF BLOOD WAS COLLECTED) How was blood collected? (1040) ☐₁ Venipuncture ☐₂ Capillary

6. Were the following vacutainers collected?

Priority Order	Specimen type	Vacutainer volume	
1	EDTA (purple)/Capillary		(1050) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
2	ACD-A citrate (yellow)	3 mL for DNA	(1060) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No

- IF DNA SAMPLES WERE NOT COLLECTED, PREPARE TO ATTEMPT THE DNA BLOOD DRAW AT THE V24M VISIT.
- COMPLETE THE SITE SPECIFIC WORKSHEET.





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

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN COLLECTION:
BLOOD

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: 1 2 M

Visit Date: ____ / ____ / ____

Coordinator ID: ____

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN 2+
COLLECTION: BLOOD

Participant ID: 2 - - - - -

Participant Initials: - - - - -

Visit Number: 1 2 M

Date: - - - / - - - / - - - - -

Coordinator ID: - - - - -

1. (FOR HOME VISIT SITES ONLY) Was the collection completed in the participant's home?

(1000) ☐₁ Yes ☐₀ 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 (0.175 ml) of plasma collected?

(1030) ☐₁ Yes ☐₀ 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 V12M WITHIN THE VISIT WINDOW.

→ IF NO, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT 12M CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE AND COMPLETE THE ASSESS-AKI WITHDRAWAL (WITHDR) FORM.

5. (COMPLETE ONLY IF BLOOD WAS COLLECTED) How was blood collected?

(1040) ☐₁ Venipuncture
☐₂ Capillary

6. Were the following vacutainers collected?

Priority Order	Specimen type	Vacutainer volume	
1	EDTA (purple)		(1050) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
2	ACD-A citrate (yellow)	3 mL for DNA	(1060) <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No

→ IF DNA SAMPLES WERE NOT COLLECTED, PREPARE TO ATTEMPT THE DNA BLOOD DRAW AT THE V24M VISIT.

→ COMPLETE THE SITE SPECIFIC WORKSHEET.





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

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN 2+
COLLECTION:BLOOD

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: 1 2 M

Date: ____ / ____ / ____

Coordinator ID: ____

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN COLLECTION:
URINE

Participant ID: 2 - - - -
Participant Initials:
Visit Number: 1 2 M
Visit Date: / / - - -
Coordinator ID:

1. (FOR HOME VISIT SITES ONLY) Was the visit completed in the participant's home? (1000) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No
5. How was the urine sample collected? (1040) ☐₁ Midstream
☐₂ Cotton ball
☐₃ Bag

6. Was the minimum amount of urine collected? (1050) ☐₁ Yes ☐₀ 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 V12M SPECIMEN 2+ COLLECTION:URINE (P2_V12M_COLLECT_UA_2) FORM.
- ➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD, RESCHEDULE ANOTHER V12M WITHIN THE VISIT WINDOW.
- ➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT 12M CANNOT BE COMPLETED WITHIN THE VISIT WINDOW, STOP HERE AND COMPLETE THE ASSESS-AKI WITHDRAWAL (WITHDR) FORM

➔ COMPLETE THE SITE SPECIFIC WORKSHEET.

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN 2+
COLLECTION: URINE

Participant ID: 2 - - - - -

Participant Initials: - - - - -

Visit Number: 1 2 M

Date: - - - / - - - / - - - - -

Coordinator ID: - - - - -

1. (FOR HOME VISIT SITES ONLY) Was the collection completed in the participant's home?

(1000) ☐₁ Yes ☐₀ 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) ☐₁ Yes ☐₀ No

5. How was the urine sample collected?

(1040) ☐₁ Midstream
☐₂ Cotton ball
☐₃ Bag

6. Was the minimum amount of urine collected?
DIAPER WEARERS SHOULD PROVIDE 1.6 ML
NON-DIAPER WEARERS SHOULD PROVIDE 5 ML

(1050) ☐₁ Yes ☐₀ 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 V12M WITHIN THE VISIT WINDOW.

➔ **IF NO**, AND ANOTHER COLLECTION CANNOT BE SCHEDULED WITHIN THE 48-HOUR PERIOD AND ANOTHER VISIT 12M 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 V12M
SPECIMEN PROCESSING

Participant ID: 2 - ____ - ____
Participant Initials: ____
Visit Number: 1 2 M
Visit Date: ____ / ____ / ____
Coordinator ID: ____

Blood Specimen Processing

1. Are there any blood samples to be processed? (1000) ☐₁ Yes ☐₀ No
➔ IF **NO**, COMPLETE THE SITE SPECIFIC WORKSHEET AND PROCEED TO QUESTION 8.
2. Do you have less than or equal to the minimum amount (0.175 mL) of plasma to process? (1010) ☐₁ Yes ☐₀ No
➔ IF YOU HAVE MORE THAN THE MINIMUM AMOUNT (0.175 mL) OF PLASMA, PROCEED TO QUESTION 3.
 - 2a. Is there a 0.150 mL aliquot? (1020) ☐₁ Yes ☐₀ No
 - 2b. Is there a 0.025 mL aliquot? (1030) ☐₁ Yes ☐₀ No
➔ PROCEED TO QUESTION 6.
3. How many 0.5 mL aliquots were produced? (1040) ____ aliquots
(ASSESS-AKI goal 1 X 0.5 mL)
4. How many 0.25 mL aliquots were produced? (1050) ____ aliquots
(ASSESS-AKI goal 4 X 0.25 mL)
5. Is there an extra aliquot? (1060) ☐₁ Yes ☐₀ No
 - 5a. If YES, estimate volume of additional plasma saved. (1070) ____ . ____ mL
6. Date samples frozen (1080) ____ / ____ / ____
MM DD YYYY
7. Time samples frozen (1090) ____
RECORD TIME USING A 24-HOUR CLOCK.
(Aliquots should be stored in a -80 freezer)

Urine Specimen Processing

8. Are there any urine samples to be processed? (1100) ☐₁ Yes ☐₀ No
➔ IF **NO**, COMPLETE THE SITE SPECIFIC WORKSHEET AND PROCEED TO BIOLOGICAL SAMPLE TRACKING MODULE.
9. How many 1.0 mL aliquots of urine were produced? (1110) ____ aliquots
(ASSESS-AKI goal – 10 X 1.0 mL)
10. (COMPLETE ONLY IF DIAPER-WEARER) Is there an extra aliquot of less than 1.0 mL? (1120) ☐₁ Yes ☐₀ No





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

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN PROCESSING

Participant ID: 2 - ____ - ____

Participant Initials: ____

Visit Number: 1 2 M

Visit Date: ____ / ____ / ____

Coordinator ID: ____

11. How many 10 mL aliquots of urine were produced?
(ASSESS-AKI goal – 1 X 10 mL)

(1130) ____ aliquots

12. Is there an extra aliquot of less than 10 mL?

(1140) ☐₁ Yes ☐₀ No

13. Date samples frozen

(1150) ____ / ____ / ____
MM DD YYYY

14. Time samples frozen
RECORD TIME USING A 24-HOUR CLOCK.
(Aliquots should be stored in a -80 freezer)

(1160) ____

Comments:

(6000) : _____





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

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN PROCESSING
2+

Participant ID: 2 - - - -
Participant Initials:
Visit Number: 1 2 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) ☐₁ Yes ☐₀ No
➔ IF **NO**, COMPLETE THE SITE SPECIFIC WORKSHEET
AND PROCEED TO QUESTION 9.
3. Do you have less than or equal to the minimum amount
(0.175 mL) of plasma to process? (1010) ☐₁ Yes ☐₀ No
➔ IF YOU HAVE MORE THAN THE MINIMUM AMOUNT
(0.175 mL) OF PLASMA, PROCEED TO QUESTION 4.
- 3a. Is there a 0.150 mL aliquot? (1020) ☐₁ Yes ☐₀ No
- 3b. Is there a 0.025 mL aliquot? (1030) ☐₁ Yes ☐₀ No
➔ PROCEED TO QUESTION 7.
4. How many 0.5 mL aliquots were produced? (1040) aliquots
(ASSESS-AKI goal 1 X 0.5 mL)
5. How many 0.25 mL aliquots were produced? (1050) aliquots
(ASSESS-AKI goal 4 X 0.25 mL)
6. Is there an extra aliquot? (1060) ☐₁ Yes ☐₀ No
- 6a. If YES, estimate volume of additional plasma saved. (1070) . mL
7. Date samples frozen (1080) / / - - -
MM DD YYYY
8. Time samples frozen (1090)
(RECORD TIME USING A 24-HOUR CLOCK)
(Aliquots should be stored in a -80 freezer)

Urine Specimen Processing

9. Are there any urine samples to be processed? (1100) ☐₁ Yes ☐₀ 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? (1110) aliquots
(ASSESS-AKI goal – 10 X 1.0 mL)





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

ASSESS AKI
PEDIATRIC
OUTPATIENT V12M
SPECIMEN PROCESSING
2+

Participant ID: 2 - ____ - ____
Participant Initials: ____
Visit Number: 1 2 M
Visit Date: ____ / ____ / ____
Coordinator ID: ____

11. (COMPLETE ONLY IF DIAPER-WEARER) Is there an extra aliquot of less than 1.0 mL? (1120) ☐₁ Yes ☐₀ No
12. How many 10 mL aliquots of urine were produced? (1130) ____ aliquots
(ASSESS-AKI goal – 1 X 10 mL)
13. Is there an extra aliquot of less than 10 mL? (1140) ☐₁ Yes ☐₀ No
14. Date samples frozen (1150) ____ / ____ / ____
MM DD YYYY
15. Time samples frozen (1160) ____
RECORD TIME USING A 24-HOUR CLOCK
(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
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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2.	It is hard for me to run (1010)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3.	It is hard for me to do sports activity or exercise (1020)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.	It is hard for me to lift something heavy (1030)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5.	It is hard for me to take a bath or shower by myself (1040)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6.	It is hard for me to do chores around the house (1050)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
8. I have low energy	(1070)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

About my Feelings (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
9. I feel afraid or scared	(1080)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
10. I feel sad or blue	(1090)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
11. I feel angry	(1100)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
12. I have trouble sleeping	(1110)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
13. I worry about what will happen to me	(1120)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
15. Other kids do not want to be my friend	(1140)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4





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: ____

How I Get Along with Others (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
16. Other kids tease me	(1150)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
17. I cannot do things that other kids my age can do	(1160)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
18. It is hard to keep up when I play with other kids	(1170)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

About School (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
19. It is hard to pay attention in class	(1180)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
20. I forget things	(1190)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
21. I have trouble keeping up with my schoolwork	(1200)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
22. I miss school because of not feeling well	(1210)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
23. I miss school to go to the doctor or hospital	(1220)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4





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

ASSESS AKI
PedsQL™
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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2. Running	(1010)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3. Participating in sports activity or exercise	(1020)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4. Lifting something heavy	(1030)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5. Taking a bath or shower by him or herself	(1040)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6. Doing chores around the house	(1050)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7. Having hurts or aches	(1060)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8. Low energy level	(1070)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





ASessment,
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NIH/NIDDK

ASSESS AKI
PedsQL™
PARENT REPORT for
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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
10. Feeling sad or blue	(1090)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
11. Feeling angry	(1100)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
12. Trouble sleeping	(1110)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
13. Worrying about what will happen to him or her	(1120)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

Social Functioning (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
14. Getting along with other teens	(1130)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
15. Other teens not wanting to be his or her friend	(1140)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
16. Getting teased by other teens	(1150)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
17. Not able to do things that other teens his or her age can do	(1160)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
18. Keeping up with other teens	(1170)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

School Functioning (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
19. Paying attention in class	(1180)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
20. Forgetting things	(1190)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
21. Keeping up with schoolwork	(1200)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4





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

ASSESS AKI
PedsQL™
PARENT REPORT for
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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23. Missing school to go to the doctor or hospital	(1220)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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

ASSESS AKI
PedsQL™
PARENT REPORT for
YOUNG CHILDREN
(Ages 2-4)

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	(1000)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2. Running	(1010)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3. Participating in active play or exercise	(1020)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4. Lifting something heavy	(1030)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5. Bathing	(1040)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6. Helping to pick up his or her toys	(1050)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7. Having hurts or aches	(1060)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8. Low energy level	(1070)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





ASsessment,
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ASSESS AKI
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PARENT REPORT for
YOUNG CHILDREN
(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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10. Feeling sad or blue	(1090)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11. Feeling angry	(1100)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
12. Trouble sleeping	(1110)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
13. Worrying	(1120)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Social Functioning (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
14. Playing with other children	(1130)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15. Other kids not wanting to play with him or her	(1140)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16. Getting teased by other children	(1150)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17. Not able to do things that other children his or her age can do	(1160)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18. Keeping up when playing with other children	(1170)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20. Missing school/daycare because of not feeling well	(1190)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
21. Missing school/daycare to go to the doctor or hospital	(1200)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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(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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2. Running	(1010)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3. Participating in sports activity or exercise	(1020)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4. Lifting something heavy	(1030)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5. Taking a bath or shower by him or herself	(1040)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6. Doing chores, like picking up his or her toys	(1050)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7. Having hurts or aches	(1060)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8. Low energy level	(1070)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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(Ages 5-7)

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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10. Feeling sad or blue	(1090)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11. Feeling angry	(1100)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
12. Trouble sleeping	(1110)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
13. Worrying about what will happen to him or her	(1120)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Social Functioning (problems with...)

14. Getting along with other children	(1130)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15. Other kids not wanting to be his or her friend	(1140)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16. Getting teased by other children	(1150)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17. Not able to do things that other children his or her age can do	(1160)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18. Keeping up when playing with other children	(1170)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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PARENT REPORT for
YOUNG CHILDREN
(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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20. Forgetting things	(1190)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
21. Keeping up with school activities	(1200)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22. Missing school because of not feeling well	(1210)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23. Missing school to go to the doctor or hospital	(1220)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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(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 **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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2. Running	(1010)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3. Participating in sports activity or exercise	(1020)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4. Lifting something heavy	(1030)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5. Taking a bath or shower by him or herself	(1040)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6. Doing chores around the house	(1050)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7. Having hurts or aches	(1060)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8. Low energy level	(1070)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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(Ages 8-12)

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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
10. Feeling sad or blue	(1090)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
11. Feeling angry	(1100)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
12. Trouble sleeping	(1110)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
13. Worrying about what will happen to him or her	(1120)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

Social Functioning (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
14. Getting along with other children	(1130)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
15. Other kids not wanting to be his or her friend	(1140)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
16. Getting teased by other children	(1150)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
17. Not able to do things that other children his or her age can do	(1160)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
18. Keeping up with other children	(1170)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

School Functioning (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
19. Paying attention in class	(1180)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
20. Forgetting things	(1190)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
21. Keeping up with schoolwork	(1200)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4





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CHILDREN
(Ages 8-12)

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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23. Missing school to go to the doctor or hospital	(1220)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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TEEN REPORT
(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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2.	It is hard for me to run	(1010) <input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3.	It is hard for me to do sports activity or exercise	(1020) <input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.	It is hard for me to lift something heavy	(1030) <input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5.	It is hard for me to take a bath or shower by myself	(1040) <input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6.	It is hard for me to do chores around the house	(1050) <input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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Serial Evaluation, and
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TEEN REPORT
(Ages 13-<18)

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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
8. I have low energy	(1070)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

About my Feelings (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
9. I feel afraid or scared	(1080)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
10. I feel sad or blue	(1090)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
11. I feel angry	(1100)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
12. I have trouble sleeping	(1110)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
13. I worry about what will happen to me	(1120)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
15. Other teens do not want to be my friend	(1140)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4





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TEEN REPORT
(Ages 13-<18)

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 teens tease me	(1150)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
17. I cannot do things that other teens my age can do	(1160)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
18. It is hard to keep up with my peers	(1170)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

About School (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
19. It is hard to pay attention in class	(1180)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
20. I forget things	(1190)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
21. I have trouble keeping up with my schoolwork	(1200)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
22. I miss school because of not feeling well	(1210)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
23. I miss school to go to the doctor or hospital	(1220)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4





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YOUNG ADULT REPORT
(Ages 18-25)

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"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2.	It is hard for me to run (1010)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3.	It is hard for me to do sports activity or exercise (1020)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.	It is hard for me to lift something heavy (1030)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5.	It is hard for me to take a bath or shower by myself (1040)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6.	It is hard for me to do chores around the house (1050)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄





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: ____

About my Health and Activities (problems with ...)

		Never	Almost never	Sometimes	Often	Almost always
7. I hurt or feel pain	(1060)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
8. I have low energy	(1070)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

About my Feelings (problems with...)

		Never	Almost never	Sometimes	Often	Almost always
9. I feel afraid or scared	(1080)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
10. I feel sad or blue	(1090)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
11. I feel angry	(1100)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
12. I have trouble sleeping	(1110)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
13. I worry about what will happen to me	(1120)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
15. Other young adults do not want to be my friend	(1140)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4





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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
17.	I cannot do things that others my age can do (1160)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
18.	It is hard to keep up with my peers (1170)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

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"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
20.	I forget things (1190)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
21.	I have trouble keeping up with my work or studies (1200)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
22.	I miss work or school because of not feeling well (1210)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
23.	I miss work or school to go to the doctor or hospital (1220)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4





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.





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: ____

		Not at all	Sometimes	A lot	
1.	It is hard for you to walk.	(1000)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
2.	It is hard for you to run.	(1010)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
3.	It is hard for you to play sports or exercise.	(1020)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
4.	It is hard for you to pick up big things.	(1030)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
5.	It is hard for you to take a bath or shower.	(1040)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
6.	It is hard for you to do chores (like pick up your toys).	(1050)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
7.	Do you have hurts or aches? (Where? _____)	(1060)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
8.	Do you ever feel too tired to play?	(1070)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄





ASsessment,
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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: ____

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"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
10. Do you feel sad?	(1090)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
11. Do you feel mad?	(1100)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
12. Do you have trouble sleeping?	(1110)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
13. Do you worry about what will happen to you?	(1120)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄

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"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
15. Do other kids say they do not want to play with you?	(1140)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
16. Do other kids tease you?	(1150)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
17. Can other kids do things that you cannot do?	(1160)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
18. Is it hard for you to keep up when you play with other kids?	(1170)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄





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"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
20. Do you forget things?	(1190)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
21. Is it hard to keep up with schoolwork?	(1200)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
22. Do you miss school because of not feeling good?	(1210)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄
23. Do you miss school because you have to go to the doctor's or hospital?	(1220)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₂	<input type="checkbox"/> ₄





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

ASSESS AKI PROCEDURE INVESTIGATION

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ - __ - __

Visit Number: __ - __ - __

Visit Date: __ / __ / __ - __ - __

Coordinator ID: __ - __ - __ - __ - __

DO NOT ENTER.

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

__ / __ / __ - __ - __
MM DD YYYY

COORDINATORS SHOULD COMPLETE A SEPARATE PROCEDURE INVESTIGATION (PI) FORM FOR
EACH EVENT THAT IS DETERMINED

1. Date of Test/Procedure: (1000) __ / __ / __ - __ - __
MM DD YYYY
2. Which one of the following ambulatory procedure/treatments are you investigating?
(Check ONE procedure)
 - 2a. Surgery (amputation or other surgery) or balloon angioplasty to open a blockage in blood vessels in the arms, legs, or abdomen (1010) ☐₁ Yes ☐₀ No
 - 2b. Surgery (carotid endarterectomy) or balloon angioplasty or stent to open a blockage in blood vessels in the neck (1020) ☐₁ Yes ☐₀ No
3. Did a physician review the ambulatory procedure/treatments you are investigating? (1030) ☐₁ Yes ☐₀ No

Comments:

(6000) _____





ASessment,
Serial **E**valuation, and
Subsequent **S**equelae in AKI
NIH/NIDDK

ASSESS AKI SHORT PHYSICAL EXAM

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

Participant Initials: _ _ _ _

Visit Number: _ _ _ _

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

Coordinator ID: _ _ _ _ _

1. Is the participant able to stand for height and weight measurements?

(1000) ☐₁ Yes ☐₀ No

➔ IF **YES**, RECORD HEIGHT AND WEIGHT BELOW.

Standing Height

(1010) _ _ _ _ . _ cm

Standing Weight

(1020) _ _ _ _ . _ kg

➔ IF **NO**, ASK THE PARTICIPANT TO REPORT HEIGHT AND WEIGHT.

FOR US UNITS OF MEASUREMENT

Height

(1030/1040) _ _ ft _ _ in

Weight

(1050) _ _ _ _ lbs

FOR METRIC UNITS OF MEASUREMENT

Height

(1060) _ _ _ _ . _ cm

Weight

(1070) _ _ _ _ . _ kg

- 1a. IF **NO**: IS THE PARTICIPANT UNABLE TO STAND DUE TO AN AMPUTATION?

(1080) ☐₁ Yes ☐₀ No

FOR PEDIATRIC PARTICIPANTS ONLY

2. Height percentile for age and gender
3. Weight percentile for age and gender

(1090) _ _ _ _ %

(1100) _ _ _ _ %

Comments:

(6000) : _____



Your Health and Well-Being

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. <u>Accomplished less</u> than you would like	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. Were limited in the <u>kind</u> of work or other activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 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. <u>Accomplished less</u> than you would like	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. Did work or other activities <u>less carefully than usual</u>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 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.)?

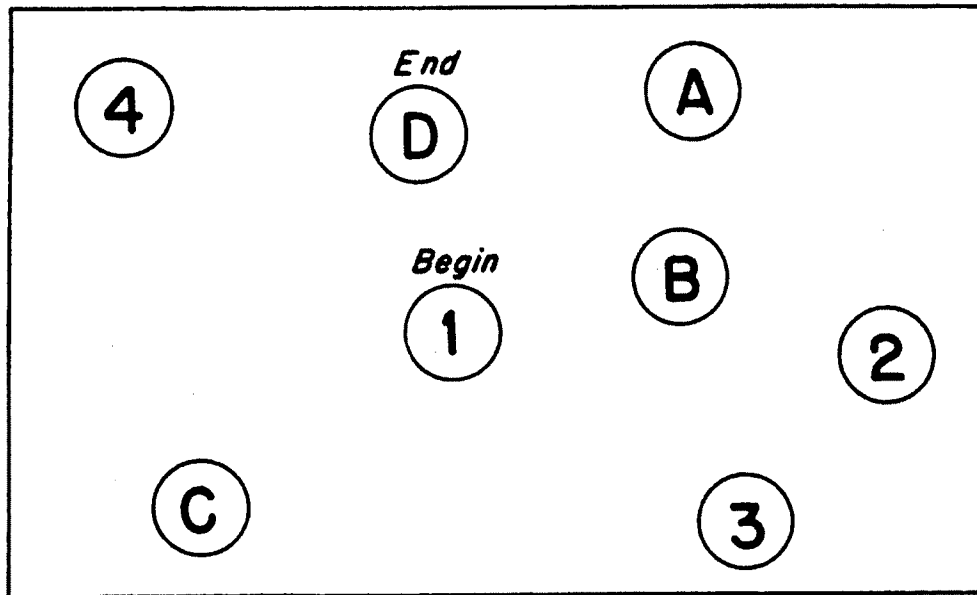
All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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

11

K



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

ASSESS AKI TRAILSB SCORING

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

Participant Initials: _ _ _ _

Visit Number: _ _ _ _

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

Coordinator ID: _ _ _ _

1. How many years of school has the participant completed?
(GED=12 YEARS) (1000) _ _ _ years
2. Number of seconds required to complete the task
(IF THE PARTICIPANT HAS NOT COMPLETED THE TASK AFTER 5 MINUTES, STOP THE TASK AND ENTER 999 FOR THIS FIELD) (1010) _ _ _ _ seconds

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
UNITED STATES
SERUM CREATININE
FROM OTHER SOURCES

Participant ID: __ - __ - __ - __ - __

Participant Initials: __ __ __

Visit Number: __ __ __

Visit Date: __ / __ / __ - __ - __

Coordinator ID: __ __ __ __

This form records the serum creatinine value in the outpatient phase that was processed and provided by other sources and was not provided by the ASSESS-AKI Central Lab.

1. Source of authorization to obtain results: (1000) ☐₁ Consent
☐₂ Medical records release
2. Is this an outpatient, non-emergency department test value nearest to the in-person ASSESS value?
➔ If **NO** or **DON'T KNOW**, STOP HERE. (1010) ☐₁ Yes
☐₀ No
☐₉₈ Don't Know
3. Date of blood collection: (1020) __ __ / __ __ / __ __ - __ __ - __ __
MM DD YYYY
4. Serum creatinine (1030) __ __ . __ 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) ☐₁ Yes ☐₀ No

1a. IF **NO**: INDICATE **PRIMARY** REASON FOR
WITHDRAWAL:

- (1010) ☐₁ Ineligible due to inpatient blood collection
☐₂ Ineligible due to inpatient urine collection
☐₃ Ineligible due to inpatient blood and urine collection
☐₄ Ineligible (unrelated to blood/urine collection) prior to three-month visit
☐₅ Ineligible at three-month visit
☐₆ No longer willing to follow the protocol/interested in participating
☐₇ Lost to follow-up
☐₈ Participant has personal constraints
☐₉ Deceased
☐₉₆ 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) ☐₁ Yes ☐₀ No

IF **YES**: WHICH SPECIMENS DID THE
PARTICIPANT WANT DISPOSED?

1ci. Serum/Plasma

(1040) ☐₁ Yes ☐₀ No

1cii. DNA samples

(1050) ☐₁ Yes ☐₀ No

1ciii. Urine

(1060) ☐₁ Yes ☐₀ No

Comments:

(6000) : _____

