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VA WEST HAVEN CSP530

ITE PENAL FALLURE TRIAL NETWORK (ATN STUDY)

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ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY)
FORM 18V - 12 MONTH FOLLOW-UP FOR VA PATIENTS

<u> </u>					D	ate
Hospit	al Pa ⁻	tID	PatInits	5	Date Form Comple	eted
					//	
1. Has the pati	ent died?				Death	Yes No □ □
If Yes, a.	Date of Death	DeathDat	e /		(mm/dd/yy)	
	A system. I am or	•		eived since	patient] may have re , th D-Day survey date)	e date of the
_	y survey date)	e [you/patient]	admitted to a	ny hospital <u>outsi</u>	ide the VA System?	Yes No HospAdmit
If Yes, a.	Admission date: -		AdmitD	ate /	′	(mm/dd/yy)
b.	Facility name:				HospFacility	
C.	City and state wh	ere facility loc	ated:	HospCity	HospState	
d.	How many days d	id [you/patient] stay in that h	nospital?	Days	HospDays
e.	How many days w	ere [you/patier	nt] in the Inter	nsive Care Unit?	Days	I CUDays
f.					□ no Addition	
	If Yes, use the	e continuation	sheets on pag	es 4 and 5 to 1	record additional ho	spital admissions.
3. Since	, were	e [you/patient]	admitted to a	ny nursing home	outside the VA Sys	Yes No
(60-da If Yes,	y survey date)					NursingHome
	Admission date:	NHAdmi	tDate		/ (mm/dd	/yy)
b.	Facility name:				NHFacilit	ty
C.	City and state wh	ere facility loc	ated:	NHCit	ty NHState	
						NHDays
	How many days w				Day	VS
e.	Have there been If Yes,			ssions? s on pages 4 ar		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\

additional nursing home admissions.

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	Hospital PatI D PatI nits
4.	Since, were [you/patient] admitted to any hospice outside the VA System? Yes No
	h Facility name: HospiceAdmitDate
	b. Facility name: HospiceFacility
	c. City and state where facility located: HospiceCity HospiceState
	d. How many days were [you/patient] in the hospice?
	e. Has there been additional hospice admissions? HospiceAddAdmit uses uno
	If Yes, use the continuation sheets on pages 4 and 5 to record additional hospice admissions.
	Now I'd like to ask about outpatient care, such as doctor appointments and visits to dialysis clinics. I'm only interested in outpatient visits <u>outside the VA system</u> .
5.	Since, have [you/patient] seen a doctor <u>outside the VA</u> concerning your
	(60-day survey date) kidney problems? ————————————————————————————————————
	If Yes, a. How many times? Appointments
	b. How many miles do [you/patient] travel each way, on average? DrMilesTravel miles
	c. Did someone go with [you/patient] most times?
6.	Since, have [you/patient] received regular kidney dialysis treatment
	(60-day survey date) outside the VA system? Dialysis Ves □ □
	a. How many times per week did they occur? DialPerWeek
	b. How many miles each way did [you/patient] travel for treatment? DialMilesTravel miles
	c. Did someone go with [you/patient] most times? DialAlone □ yes □ no

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H	Hospital PatID PatInits
7.	Since, have [you/patient] had medical appointments outside the VA System (60-day survey date) for something other than kidney problems? If Yes, a. How many visits? MedCare MedCare MedCare MedCare MedCare
	b. How many miles each way did [you/patient] travel, on average? MedCareMiles miles c. Did someone go with [you/patient] most times? yes □ no MedCareAlone
8.	In the last week has someone helped [you/patient] around the house with healthcare, such as changing bandages or giving you medication? If yes, a. How many hours did someone help you with healthcare last week? HHCPerWeel
	Now I'd like to ask you about prescription medications.
9.	Since, have you obtained a prescription at any pharmacy other than a
	a. About how many presciptions was that?PrescriptionsNo

Hospital	PatID	PatInits		
ISE THIS PAGE TO RECOR	D ADDITIONAL ADM			
10. Type (check one):	□ hospital AdmitDat		ospice FacilityType	21
a. Admission date	e: / /	/ (mm/dd/y		1
b. Facility name			AddFacility	<u> </u>
c. City and state	where facility located:	: AddCi	ty1 AddState	1
d. How many day	s were [you/patient] th	nere?		days Days1
o. For bospital st	rave how many days wa	uro coont in an Intonciu	vo Caro Unit?	days
e. For nospital st	ays, how many days we	FacilityType2	ve care onit?	I CUDays1
11. Type (check one):	L	<u> </u>		
	AdmitDat	te2		
a. Admission dat	e: / /	(mm/dd/ <u>y</u>	yy)	
b. Facility name			AddFacility2	
c. City and state	where facility located:	: AddCi1	ty2 AddState2	1
d. How many day	s were [you/patient] th	nere?		days Days2
e. For hospital s	tays, how many days we			days I CUDays2
12. Type (check one):	□ hospital □ nursi AdmitDat		FacilityType3	
a. Admission date	e:	/ mm (dd /)	n.d	
b. Facility name		/ (mm/dd/y	AddFacility3	
c. City and state	where facility located:	:		
	AddCity3		Adds	State3
d. How many days	s were [you/patient] th			days Days 3
, ,	ays, how many days wei		re Care Unit?	days I CUDays3
·		-		

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	TOTAL TOV	12 100141		-011 01	1010	,	21410		
Hospital	PatID		Patl	nits					
USE THIS PAGE TO RECO	RD ADDITIC	NAL ADM	SSION	IS TO F	IOSPITA	LS, N	URSI NG I	HOMES,	OR HOSPICE.
13. Type (check on	e):	_{ital □ nur} \dmitDa	sing hor	me □I	hospice F	acili	tyType	4	
a. Admission d	ate:	/	/	(mr	m/dd/yy)				
b. Facility name	9						AddFac	ility4	
c. City and sta	te where faci	lity located	:		AddCit	y4 /	AddSta	ite4	
d. How many d	ays were [you	ı/patient] t	nere?		1 1 1			da	ays Days4
e. For hospital	stays, how m	any days we	ere spen	t in an I	ntensive (Care Ui	nit?	da	ays I CUDays
14. Type (check on		al □ nurs AdmitDa	ing hom	e □h	ospice Fa	acilit	уТуре5		
a. Admission d		/	/ [(m	m/dd/yy)				
b. Facility name	<u> </u>	,	J ′			1	AddFac	ility5	
c. City and sta	te where faci	lity located	:		AddCit	:y5	AddS	tate5	
d. How many d	ays were [you	ı/patient] t	nere?						days Days5
e. For hospital	stavs, how m	anv davs we	ere spen	t in an I	ntensive (Care Ui	nit?]
	, , , , , , , , , , , , , , , , , , ,	_	•	уТуре					days I CUDays5
15. Type (check one	<i>2</i>). □			ng home		oice			
	A	dmitDat		3	•				
a. Admission da	ate:	/ 🔲	$/\Box$	(mm	n/dd/yy)	_			
b. Facility name	;						AddFac	ility6	
c. City and stat	te where faci	lity located			dC:+,./			-1-104-	1 - 1
				Ad	dCity6			ddSta 	<u>te6</u>
d. How many da	ays were [you	/patient] th	ere?						days Days6
e. For hospital	stays, how ma	any days we	re spent	t in an I r	ntensive C	are Ur	nit?		days
VA Form 10-21067 (NR)-18V						ICL	JDays6		_

VA WEST HAVEN CSP530 ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY) FORM 18V - 12 MONTH FOLLOW-UP FOR VA PATIENTS

Hospital PatI D PatI nits
FOR STUDY COORDINATOR USE ONLY
 Who answered the questions on this form (check one)?
☐ Study Subject WhoAnswered
☐ Someone who lives with the subject
☐ Someone who does not live with the subject
□ No-one
AllQuestions
2. Were all questions answered? ☐ Yes ☐ No If No, please give reason:
AllQuestionsDesc
3. If the questionnaire was not completed, indicate the main reason (check one)
☐ Subject deceased and no-one esle was availabale
☐ Subject could not be contacted NotComplete
☐ Subject refused to complete
$\hfill\square$ Subject could not complete due to illness or other reason and no-one else was available
\square Questionnaire not administered due to institution error
☐ Other, specify
NotCompleteDesc

StaffInits