



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

Hospital		

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4. Since \_\_\_\_\_, were [you/patient] admitted to any hospice outside the VA System? Yes ☐ No ☐
- (60- day survey date)
- If Yes,
- a. Admission date: -----   /   /   (mm/dd/yy) HospiceAdmitDate
- b. Facility name: HospiceFacility
- c. City and state where facility located: HospiceCity HospiceState
- d. How many days were [you/patient] in the hospice? ----- HospiceDays    Days
- e. Has there been additional hospice admissions? HospiceAddAdmit ☐ yes ☐ no
- 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 outside the VA system.

5. Since \_\_\_\_\_, have [you/patient] seen a doctor outside the VA concerning your  
(60-day survey date)  
kidney problems? ----- Doctor ☐ Yes ☐ No
- 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? ----- DrAlone ☐ yes ☐ no
6. Since \_\_\_\_\_, have [you/patient] received regular kidney dialysis treatment  
(60-day survey date)  
outside the VA system? ----- Dialysis ☐ Yes ☐ No
- If Yes,
- 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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7. Since \_\_\_\_\_, have [you/patient] had medical appointments outside the VA System  
(60-day survey date)

for something other than kidney problems-----

MedCare

Yes  
☐No  
☐

If Yes,

- a. How many visits?-----

MedCareTrips

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- b. How many miles each way did [you/patient] travel, on average?

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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?-----

Yes  
☐No  
☐

HHC

If yes,

- a. How many hours did someone help you with healthcare last week?

--	--	--

hours

HHCPerWeek

Now I'd like to ask you about prescription medications.

9. Since \_\_\_\_\_, have you obtained a prescription at any pharmacy other than a  
(60-day survey date)

VA pharmacy-----

Prescriptions

Yes  
☐No  
☐

If yes,

- a. About how many prescriptions was that?-----

--	--

PrescriptionsNo

Patient		

VA Form 10-21067 (NR)-18V

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USE THIS PAGE TO RECORD ADDITIONAL ADMISSIONS TO HOSPITALS, NURSING HOMES, OR HOSPICE.

13. Type (check one): ☐ hospital ☐ nursing home ☐ hospice **FacilityType4**  
**AdmitDate4**

a. Admission date: 

--	--

 / 

--	--

 / 

--	--

 (mm/dd/yy)

b. Facility name **AddFacility4**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

c. City and state where facility located: **AddCity4** **AddState4**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

d. How many days were [you/patient] there? 

--	--

 days **Days4**

e. For hospital stays, how many days were spent in an Intensive Care Unit? 

--	--

 days **ICUDays4**

14. Type (check one): ☐ hospital ☐ nursing home ☐ hospice **FacilityType5**  
**AdmitDate5**

a. Admission date: 

--	--

 / 

--	--

 / 

--	--

 (mm/dd/yy)

b. Facility name **AddFacility5**

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c. City and state where facility located: **AddCity5** **AddState5**

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d. How many days were [you/patient] there? 

--	--

 days **Days5**

e. For hospital stays, how many days were spent in an Intensive Care Unit? 

--	--

 days **ICUDays5**

15. Type (check one): ☐ hospital ☐ nursing home ☐ hospice **FacilityType6**  
**AdmitDate6**

a. Admission date: 

--	--

 / 

--	--

 / 

--	--

 (mm/dd/yy)

b. Facility name **AddFacility6**

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c. City and state where facility located: **AddCity6** **AddState6**

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d. How many days were [you/patient] there? 

--	--

 days **Days6**

e. For hospital stays, how many days were spent in an Intensive Care Unit? 

--	--

 days **ICUDays6**

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FOR STUDY COORDINATOR USE ONLY

1. Who answered the questions on this form (check one)?

☐ Study Subject

WhoAnswered
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☐ Someone who lives with the subject☐ Someone who does not live with the subject☐ No-one

AllQuestions
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2. Were all questions answered? ----- ☐ Yes ☐ No

If No, please give reason:

AllQuestionsDesc
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3. If the questionnaire was not completed, indicate the main reason (check one)

☐ Subject deceased and no-one else was available☐ Subject could not be contacted

NotComplete
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☐ Subject refused to complete☐ Subject could not complete due to illness or other reason and no-one else was available☐ Questionnaire not administered due to institution error☐ Other, specify

NotCompleteDesc
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StaffInits
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That's the end of the survey. Thank you.

Staff Initials

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