

# NUTRITIONAL ASSESSMENT AND STEROID USE (F15)

## Chronic Kidney Disease in Children (CKiD)

### SECTION A: GENERAL INFORMATION

A1. PARTICIPANT ID: AFFIX ID LABEL OR ENTER NUMBER IF ID LABEL IS NOT AVAILABLE

|\_| - |\_|\_| - |\_|\_|\_|

A2. CKiD VISIT #:

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

A3. FORM VERSION:

0 1 / 1 5 / 1 3

A4. DATE OF VISIT:

\_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_  
M M D D Y Y Y Y

A5. INTERVIEWER'S INITIALS:

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

A6. Is this study visit an irregular (accelerated) visit? Yes..... 1

No..... 2

A7. INDICATE PERSON COMPLETING THE FORM Child/Young Adult..... 1

Parent or other adult..... 2

Both (Parent and Child/Young Adult)..... 3

### SECTION B: NUTRITIONAL ASSESSMENT

The following set of questions asks about your child's appetite (or your appetite, if child/young adult participant is completing the form) and use of a nasogastric tube or gastrostomy tube. A nasogastric tube (NG tube) is a tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach. A gastrostomy tube (GT) or button are tubes that directly enter the stomach.

B1. During the past week, how would you rate (*name of child*) appetite? Please circle one choice.

Very Good..... 1 **(Skip to B2)**

Good..... 2 **(Skip to B2)**

Fair..... 3

Poor..... 4

Very Poor..... 5

a. During the past week, did (*name of child*) have an acute illness (i.e., cold, flu or tonsillitis) that altered (*name of child*) normal appetite?

Yes..... 1

No..... 2 **(Skip to B2)**

Don't Know..... -8 **(Skip to B2)**

b. During the past week, on how many days was the child ill?

\_\_\_ \_\_\_ days

Don't Know..... -8

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B2. Does (*name of child*) use a gastrostomy tube/button or Nasogastric tube (NG tube) for nutritional purposes?

- Yes..... 1  
 No..... 2 **(Skip to B3)**  
 Don't Know..... -8 **(Skip to B3)**

a. In the past year, how many months has the gastrostomy tube/button or NG tube been used?

\_\_\_ \_\_\_ months

Don't Know..... -8

B3. In a 24 hour time period, does (*name of child*) take any nutritional supplement either by mouth, bottle or feeding tube to increase the caloric intake (*Excludes vitamins and minerals, See MEDS Form*)?

- Yes..... 1  
 No..... 2 **(Skip to C1)**  
 Don't Know..... -8 **(Skip to C1)**

**Please use the following table to record the type and amount of any nutritional supplement or formula (to increase calories, protein or other nutrient intake) the child usually takes in a 24 hour period of time. This should include supplement or formula taken by mouth, bottle or feeding tube.**

**START F15s1**

	a) Name of Formula or Supplement (Ex: Similac PM 60/40, Enfamil LIPIIL, Suplena, PediaSure, Nepro, Ensure)	Amount of Formula (For pre-made liquid, use ounces; if made from powder, use teaspoons, tablespoons or cups)		d) Additional ingredients/amounts* (Ex: 2 teaspoons Polycose, 1 Tablespoon MCT oil, 2 scoops Beneprotein) *If there are no additional ingredients/amount, record "N/A"
		b) Amount	c) Unit	
B4.		___ ___	Tsp.....1 Tbsp.....2 Oz.....3 cup .....4	
B5.		___ ___	Tsp.....1 Tbsp.....2 Oz.....3 cup .....4	

**END F15s1**

### SECTION C: STEROID USE

The following questions are about your child's use of steroids.

C1. Is (*name of child*) currently taking steroids (i.e, prednisone, decadron)?

- Yes ..... 1  
 No ..... 2

C2. a. Did (*name of child*) take steroids within the past 24 months?

- Yes..... 1  
 No..... 2 **(Skip to C4)**  
 Don't Know..... -8 **(Skip to C4)**

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- b. In the past 24 months, did (*name of child*) take steroids to treat kidney disease?
- Yes..... 1  
 No..... 2  
 Don't Know..... -8
- c. Did (*name of child*) take steroids within the past 12 months?
- Yes..... 1  
 No..... 2  
 Don't Know..... -8 **(Skip to C3)**
- d. Did (*name of child*) take steroids every day or every other day for more than 2 months?
- Yes..... 1  
 No..... 2 **(Skip to C3)**  
 Don't Know..... -8 **(Skip to C3)**
- i. Were the steroids taken every day or every other day for more than 6 months?
- Yes..... 1  
 No..... 2  
 Don't Know..... -8

C3. In the past year, did (*name of child*) have any side effects from taking steroids?

- Yes..... 1  
 No..... 2 **(Skip to C4)**  
 N/A, did not take steroids in the past year -1 **(Skip to C4)**  
 Don't Know..... -8 **(Skip to C4)**

a. Please indicate whether (*name of child*) experienced any of the following side effects from taking steroids in the past year.

**(Please circle "Yes", "No" or "Don't Know" for EACH of the following.)**

	Yes	No	Don't Know
1. Weight gain.....	1	2	-8
2. Change in mood.....	1	2	-8
3. Hyperactivity.....	1	2	-8
4. Acne.....	1	2	-8
5. Increased blood pressure.....	1	2	-8
6. Elevated blood sugar.....	1	2	-8
7. Increased appetite.....	1	2	-8
8. Insomnia.....	1	2	-8

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C4 Is this a study Visit 1a?

Yes ..... 1  
 No ..... 2 **(END)**

C5. Has (*name of child*) ever taken steroids?

Yes..... 1  
 No..... 2 **(END)**  
 Don't Know..... -8 **(END)**

C6. Did (*name of child*) ever take steroids to treat kidney disease?

Yes..... 1  
 No..... 2  
 Don't Know..... -8

C7. What was the age of (*name of child*) when he/she first began taking steroids?

\_\_\_\_ \_\_\_\_ 1 = years  
 2 = months  
 3 = days  
 -8 = don't know

C8. Did (*name of child*) ever have any side effects from taking steroids?

Yes..... 1  
 No..... 2 **(END)**  
 Don't Know..... -8 **(END)**

a. Please indicate whether (*name of child*) ever experienced any of the following side effects from taking steroids.

**(Please circle "Yes", "No" or "Don't Know" for EACH of the following.)**

	Yes	No	Don't Know
1. Weight gain.....	1	2	-8
2. Change in mood.....	1	2	-8
3. Hyperactivity.....	1	2	-8
4. Acne.....	1	2	-8
5. Increased blood pressure.....	1	2	-8
6. Elevated blood sugar.....	1	2	-8
7. Increased appetite.....	1	2	-8
8. Insomnia.....	1	2	-8