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: 1 0 / 0 1 / 1 2

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

Chronic Kidney Disease in Children

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 <u>24 hour period of time</u>. This should include supplement or formula taken by mouth, bottle or feeding tube.

<u>START F15s1</u>

	a) Name of Formula or Supplement (Ex: Similac PM 60/40, Enfamil LIPIL, 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	

<u>END F15s1</u>

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 **(Skip to C3)**
No 2

a. Is this a study Visit 1a?

Yes 1
No ..... 2 **(Skip to C4b)**

C2. Has *(name of child)* ever taken steroids?

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

C3. 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

C4. a. Did *(name of child)* take steroids to treat kidney disease?

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

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

Yes..... 1
No..... 2 **(Skip to C4d)**
Don't Know..... -8 **(Skip to C5)**

c. Did *(name of child)* take steroids within the past 12 months?

Yes..... 1
No..... 2
Don't Know..... -8 **(Skip to C5)**

d. Did *(name of child)* take steroids every day or every other day for more than 2 months?

Yes..... 1
No..... 2
Don't Know..... -8 **(Skip to C5)**

i. Were the steroids taken every day or every other day for more than 6 months?

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

C5. 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)* 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