

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 1 / 0 1 / 1 0

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 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 cup4	
B5.		___ ___	Tsp.....1 Tbsp.....2 Oz.....3 cup4	

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 **(Skip to C3)**
 No 2

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

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

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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