

# NUTRITIONAL ASSESSMENT (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 4a

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 the participant'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 participant*) 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 participant*) have an acute illness (i.e., cold, flu or tonsillitis) that altered (*name of participant*) 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

## NUTRITIONAL ASSESSMENT (F15)

B2. Does (*name of participant*) 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 participant*) 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 **(END FORM)**  
 Don't Know..... -8 **(END FORM)**

**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 cup .....4	
B5.		___ ___	Tsp.....1 Tbsp.....2 Oz.....3 cup .....4	

**END F15s1**