CRISP

Initial Screening Form

CRISP -FORM # 3

Missing Codes:
A-Participant refused
B-Reading not possible
C-Investigator forgot

Use Missing Codes to indicate reason for absent information.

This form is to be completed at the participant's screening visit.

1. **Date of Visit**: _____ / _____ / _____ DVDATE
   Month Day Year

2. **Specify Laboratory processing samples**: _____ LABIDNUM _____

3. **Participant weight:** (please circle the appropriate units used): ____ WEIGHT ____ kg pounds LBKG

BLOOD WORK:

4. **Serum creatinine concentration**: _ CREATCLR _ mg/dL **Date creatinine collected**: _____ / _____ / _____ CCDATE
   Month Day Year

5. **Date remaining blood samples were collected**: _____ / _____ / _____ RBDATE
   Month Day Year

6. **Hemoglobin**: ____ HEMOGLOB ____ g/dL **Hematocrit**: _____ HEMOTOCRIT _____ %

7. **White blood count (**circle units used**)**: ___ WHBLOOD ___ cell/µL K/µL WBCUNIT

   ANC (circle units used**)**: ___ ANC ___ neutrophils/µL K/µL ANCUNIT

8. **Platelet count (**circle units used**)**: _____ PLATELET _____ platelets/µL K/µL PLUNIT

9. **Serum (**circle units used**)**: mEq/L mmol/L S9UNIT

   Na __ SNA __ K __ SK __ Cl ___ SCL ___ HCO3 ___ SHCO __

10. **Serum (in mg/dL)**: Ca ___ SCA ___ Uric Acid ___ SURIC ___ BUN ___ SBUN ___

    glucose ___ SGLU ___ PO4 ___ SPO ___ Total bilirubin ___ SBILIR ___

11. **Serum (in U/L)**: SGOT (AST) ___ SSGOT ___ SGPT (ALT) ___ SSGPT ___ Alk Phos ___ SALK ___

Clinical Center: _____
Participant ID: _____
Visit Number: _____

URINE SAMPLES:

12. Start time of urine collection: ___URCSTIME___ am pm **End time of urine collection:** ___URCETIME___ am pm

Collection Date for start of 24 hour Urine Specimen: _____ / _____ / _____ URVDATE
Month Day Year

13. 24 hour Urine Volume: ____URINE24____ mL

14. Urine Protein Excretion: ____UPROTE____ mg/24 h **or** **Urine Protein Concentration**: ____UPROTC____ mg/dL

15. Urine Creatinine Excretion: ____UCE___ mg/24 h **or** **Urine Creatinine Concentration:** ____UCC____ mg/dL

16. Eligibility Determination (Please enter NA if not applicable):

Collection Date: _____ / _____ / _____ ELGDATE
Month Day Year

Urine Protein by Dipstick: ____UPDIP____ mg/dL

Urine Protein/Osmolality Ratio: _____UPOSMOL_____

Predicted 24 hour Urine Protein: _____PUPROT_____ mg/24 h

CRISP Member completing this form _____CMIDNUM_____ Date form completed: _____ / _____ / _____ CDDATE
Month Day Year

Contents of Form Reviewed by Principal Investigator (required signature): _____

Date Principal Investigator signed: _____ / _____ / _____ RSDATE
Month Day Year

Data Entry Status: Please check to indicate that the above information has been entered ☐

Data Entry Person _____DEIDNUM_____ Date Form Entered: _____ / _____ / _____ DEDATE
Month Day Year

Clinical Center: __PCCN__
Participant ID: __PKDID__
Visit Number: _____