CRISP III

Attention - DO NOT enter patient data on this form if the header does not contain *preprinted* CRISP ID number, clinical center ID, and visit number.

Participant ID:_____ *pkdid*
visit:

Clinical Center: _____ *pccn*

Missing Data Codes:	A-Participant Refused	B-Reading Not Possible	C-Institutional Error

Follow-Up Study and Events Form

This form is to be completed for the scheduled quarterly phone calls and as needed for unscheduled phone calls and/or visits.

☐ **Check here if data were entered from Electronic Health Records (e.g., lost to follow up) or other external data source (e.g., USRDS).**

1. Date of visit *dvdate* ☐☐ / ☐☐ / ☐☐☐☐

Type of Event: *toe* 1 ☐ Scheduled Follow-up Visit 2 ☐ Serious Adverse Event

3 ☐ Other Specify_____ *evoth*

2. Since last contact, has the participant had any illnesses ? *ilyn* 0 ☐ No **(*Go to #3*)** 1 ☐ Yes

If yes, **please specify briefly:** *ill*_____

_____

_____

2a. Have you been newly diagnosed with hypertension since last contact? *hypert* 0 ☐ No 1 ☐ Yes

If yes, **Date of diagnosis:** __ __/__ __/__ __ __ __ *hypyr*
hypmt *hypda* Month Day Year

How were you diagnosed with hypertension? *hyphdia* 1 ☐ Home BP monitor 2 ☐ Doctor visit
3 ☐ Hospital stay 4 ☐ Other Specify: _____ *hypspc*

2b. Since last contact, have you been told by a doctor or other health professional that you have diabetes or high blood sugar (If female, other than during pregnancy)? *diablowsugar* 0 ☐ No 1 ☐ Yes 2 ☐ Don't Know 9998 ☐ Missing

If no or don't know, and male participant, go to 3.
If no or don't know, and female participant, go to 2c.

If yes, date: Month ☐☐ / Day ☐☐ / Year ☐☐☐☐ *diablowsugarmt* *diablowsugarda* *diablowsugaryr*

If male participant, go to 2d.

2c. Since last contact, have you been told by a doctor or other health professional that you have/had diabetes during pregnancy? *diabpregn* 0 ☐ No 1 ☐ Yes 2 ☐ Don't Know 9998 ☐ Missing

If 2c=no or don't know, go to 3.

If yes, date: Month ☐☐ / Day ☐☐ / Year ☐☐☐☐ *diabpregnmt* *diabpregnda* *diabpregnyr*

Follow-Up Study and Events Form

2d. **Since last contact, have you taken medications for diabetes?** *diabmed*
0 ☐ No 1 ☐ Yes 2 ☐ Don't Know 777 ☐ Not Applicable 9998 ☐ Missing

If yes, medications:
_____ *diabmed1*
_____ *diabmed2*
_____ *diabmed3*
_____ *diabmed4*
_____ *diabmed5*

2e. **Since last contact, have you taken diabetic pills (also called hypoglycemic agents) to lower your blood sugar?** *diabpills*
0 ☐ No 1 ☐ Yes 2 ☐ Don't Know 777 ☐ Not Applicable 9998 ☐ Missing

2f. **Since last contact, have you taken insulin?** *insulin*
0 ☐ No 1 ☐ Yes 2 ☐ Don't Know 777 ☐ Not Applicable 9998 ☐ Missing

3. **Since last contact, has the participant visited their primary care physician?** *pvyn*
0 ☐ No **(*Go to #4*)** 1 ☐ Yes

If yes, complete Section 3

3a. Date of physician visit: __ __/__ __ /__ __ __ __ *pvyr*
pvmt *pvda* Month Day Year

3b. Were there multiple visits to this physician? *mvci*
0 ☐ No 1 ☐ Yes

3c. Name and address of physician treating participant:

Name: _____

Address: _____

City, State, Zip: _____

3d. Specify reason for visit: *pvreason* _____

_____

Follow-Up Study and Events Form

4. Since last contact, has the participant visited any physician other than the primary care physician listed in question 3? *pvotphyId* 0 ☐ No ***(Go to #5)*** 1 ☐ Yes

If yes, complete Section #4

Physician #1

a. Date of additional physician visit: __ __/__ __/__ __ __ __ *pv2yr*
pv2mt *pv2da* Month Day Year

b. Were there multiple visits to this physician? *m2vc* 0 ☐ No 1 ☐ Yes

c. Name and address of physician treating participant:

Name: _____

Address: _____

City, State, Zip:_____

d. Specify reason for visit: *pv2reason*_____

_____

_____

Physician #2

a. Date of additional physician visit: __ __/__ __/__ __ __ __ *pv2yr*
pv2mt *pv2da* Month Day Year

b. Were there multiple visits to this physician? *m2vc* 0 ☐ No 1 ☐ Yes

c. Name and address of physician treating participant:

Name: _____

Address: _____

City, State, Zip:_____

d. Specify reason for visit: *pv2reason*_____

_____

_____

Follow-Up Study and Events Form

Physician #3

a. Date of additional physician visit: __ __/__ __ /__ __ __ __ *pv2yr*
pv2mt *pv2da* Month Day Year

b. Were there multiple visits to this physician? *m2vc* 0 ☐ No 1 ☐ Yes

c. Name and address of physician treating participant:

Name: _____

Address: _____

City, State, Zip:_____

d. Specify reason for visit: *pv2reason*_____

_____

_____

Please continue on the next page

Follow-Up Study and Events Form

5. Since last contact, has the participant been hospitalized? *hospld* 0 ☐ No 1 ☐ Yes
(*Go to #6*)

If yes, complete Section #5
Hospitalization #1

a. Was this hospitalization unscheduled? *husch* 0 ☐ No 1 ☐ Yes
(See Note)

.

Note: If unscheduled, please report the event to the local IRB and send a copy to the DCIAC

b. Date admitted to hospital: __ __/__ __/__ __ __ __ *hayr*
hamt *hada* Month Day Year

c. Date discharged from hospital: __ __/__ __/__ __ __ __ *hdyr*
hdmt *hdda* Month Day Year

d. Length of stay: _____*lenst*

e. Name and address of hospital:

Name:_____

Address:_____

City, State, Zip:_____

f. Name and address of physician treating participant:

Name:_____

Address:_____

City, State, Zip:_____

g. What was the discharge diagnosis?_____*hdiag*

h. Was there any renal surgery performed? *rsurgpyn* 0 ☐ No 1 ☐ Yes
If no, go to Hospitalization #2 or Section 6 if no more hospitalizations

If yes, was the intent cyst reduction? *ceducyn* 0 ☐ No 1 ☐ Yes

i. For any renal surgery provide a date and short description:
Date of intervention: __ __/__ __/__ __ __ __ *rsiyr*
rsimt *rsida* Month Day Year
Description:_____*rsidesc*

Follow-Up Study and Events Form

Hospitalization #2

a. Was this hospitalization unscheduled? *husch* 0 ☐ No 1 ☐ Yes **(See Note)**

.

Note: If unscheduled, please report the event to the local IRB and send a copy to the DCIAC

b. Date admitted to hospital: __ __/__ __/__ __ __ __ *hayr*
hamt *hada* Month Day Year

c. Date discharged from hospital: __ __/__ __/__ __ __ __ *hdyr*
hdmt *hdda* Month Day Year

d. Length of stay: _____*lenst*

e. Name and address of hospital:

Name:_____

Address:_____

City, State, Zip:_____

f. Name and address of physician treating participant:

Name:_____

Address:_____

City, State, Zip:_____

g. What was the discharge diagnosis?_____*hdiag*

h. Was there any renal surgery performed? *resurgpyn* 0 ☐ No 1 ☐ Yes
If no, go to Hospitalization #3 or Section 6 if no more hospitalizations

If yes, was the intent cyst reduction? *ceducyn* 0 ☐ No 1 ☐ Yes

i. For any renal surgery provide a date and short description:

Date of intervention: __ __/__ __/__ __ __ __ *rsiyr*
rsimt *rsida* Month Day Year

Description:_____*rsidesc*

Follow-Up Study and Events Form

Hospitalization #3

a. Was this hospitalization unscheduled? *husch* 0 ☐ No 1 ☐ Yes **(See Note)**

.

Note: If unscheduled, please report the event to the local IRB and send a copy to the DCIAC

b. Date admitted to hospital: __ __/__ __/__ __ __ __ *hayr*
hamt *hada* Month Day Year

c. Date discharged from hospital: __ __/__ __/__ __ __ __ *hdyr*
hdmt *hdda* Month Day Year

d. Length of stay: _____*lenst*

e. Name and address of hospital:

Name:_____

Address:_____

City, State, Zip:_____

f. Name and address of physician treating participant:

Name:_____

Address:_____

City, State, Zip:_____

g. What was the discharge diagnosis?_____*hdiag*

h. Was there any renal surgery performed? *rsurgpyn* 0 ☐ No 1 ☐ Yes
If no, go to Hospitalization #4 or Section 6 if no more hospitalizations

If yes, was the intent cyst reduction? *ceducyn* 0 ☐ No 1 ☐ Yes

i. For any renal surgery provide a date and short description:

Date of intervention: __ __/__ __/__ __ __ __ *rsiyr*
rsimt *rsida* Month Day Year

Description:_____*rsidesc*

Participant ID:_____ *pkdid* **Clinical Center**: _____ *pccn*
visit:

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Follow-Up Study and Events Form

Hospitalization #4

a. Was this hospitalization unscheduled? *husch* 0 ☐ No 1 ☐ Yes **(See Note)**

.

Note: If unscheduled, please report the event to the local IRB and send a copy to the DCIAC

b. Date admitted to hospital: __ __/__ __/__ __ __ __ *hayr*
hamt *hada* Month Day Year

c. Date d ischarged from hospital: __ __/__ __/__ __ __ __ *hdyr*
hdmt *hdda* Month Day Year

d. Length of stay: _____*lenst*

e. Name and address of hospital:

Name:_____

Address:_____

City, State, Zip:_____

f. Name and address of physician treating participant:

Name:_____

Address:_____

City, State, Zip:_____

g. What was the discharge diagnosis?_____*hdiag*

h. Was there any renal surgery performed? *rsurgpyn* 0 ☐ No 1 ☐ Yes ***(Go to #6)***

If yes, was the intent cyst reduction? *ceducyn* 0 ☐ No 1 ☐ Yes

i. For any renal surgery provide a date and short description:

Date of intervention: __ __/__ __/__ __ __ __ *rsiyr*
rsimt *rsida* Month Day Year

Description:_____*rsidesc*

Follow-Up Study and Events Form

6. Prescribed medications changes:

6a. Since last contact, have prescribed drugs been added? *pmaId* 0 ☐ No 1 ☐ Yes ***(Go to #6b)***

If yes, then please record:

Prescribed Medications **added**	Date (month/year)
pma	*dpmamt* __ __/__ __ __ __ *dpmayr*

Follow-Up Study and Events Form

6b. Since last contact, have prescribed drugs been stopped/discontinued? 0 ☐ No 1 ☐ Yes
pmdId
(Go to #7a)

If yes, then please record:

Prescribed Medications **discontinued** *pmd*	Date (month/year) *dpmdmt* __ __/__ __ __ __ *dpmdyr*

Participant ID:_____ *pkdid*
visit:

Clinical Center: _____ *pccn*

Missing Data Codes:	A-Participant Refused	B-Reading Not Possible	C-Institutional Error

Follow-Up Study and Events Form

7. Over-the-counter medications changes:

7a. Since last contact, have OTC drugs been added? *omaId* 0 ☐ No 1 ☐ Yes
(Go to #7b)

If yes, then please record:

OTC Medications **added**	Date (month/year)
oma	*domamt* __ __/__ __ __ __ *domayr*

7b. Since last contact, have OTC drugs been stopped/discontinued? *omdId* 0 ☐ No 1 ☐ Yes
(Go to#8b)

If yes, then please record:

OTC Medications **discontinued**	Date (month/year)
omd	*domdmt* __ __/__ __ __ __ *domdyr*

Follow-Up Study and Events Form

8. Natural Product Use Changes:

8a. Since last contact, have Natural Products/Protein Supplements been added? *nmaId* 0 ☐ No 1 ☐ Yes ***(Go to #13b)***

If yes, then please record:

Natural Products/Protein Supplements **added**	Date (month/year)
nma	*dnmamt* __ __/__ __ __ __ *dnmayr*

8b. Since last contact, have Natural Products/Protein Supplements been stopped/discontinued? *nmdId* 0 ☐ No 1 ☐ Yes ***(Stop)***

If yes, then please record:

Natural Products/Protein Supplements **discontinued**	Date (month/year)
nmd	*dnmdmt* __ __/__ __ __ __ *dnmdyr*

Please review all contact information on the Identification Form including phone number and email address.

Participant ID:_____ *pkdid*
visit:

Clinical Center: _____ *pccn*

Missing Data Codes:	A-Participant Refused	B-Reading Not Possible	C-Institutional Error

Follow-Up Study and Events Form

CRISP Member completing this form_____
cdidnum

Date Form Completed __ __/__ __/__ __ __ __
cddate

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

Primary Entered by: _____ Date: __ __/__ __/__ __ __ __ *dedate*
deidnum

Secondary Entered by: _____ Date __ __/__ __/__ __ __ __