Frequent Hemodialysis Network
NOCTURNAL TRIAL EVALUATION OF HOME ENVIRONMENT – FORM #101

Instructions: This form is to be completed at baseline for the Nocturnal Trial only.

1. Participant ID # | 2. Alpha Code | 3. Date of Evaluation dd/mon/yyyy

HOME ASSESSMENT

For Questions 4 – 13 (*except where indicated otherwise*): 0=No, not acceptable, 1=Approved as is, 2=Simple modification required (*in the space provided, please detail modification(s) needed*), 3=Approved for use in Australia

4. a. Location of bedroom in relation to water supply?.....__
   b. If 4a=2, simple modification required, provide details:_____
   _____
5. a. Accessibility of bedroom for emergency personnel in case of emergency?.....__
   b. If 5a=2, simple modification required, provide details:_____
   _____
6. a. Two 120 volt grounded outlets on separate circuit breakers?.....__
   b. If 6a=2, simple modification required, provide details:_____
   _____
7. a. Septic or sewer capable of handling effluent? .....__
   b. Did septic tank pass the perc test? (8=Not applicable, sewer system in place).....__
   c.. If 7a or b=2, simple modification required, provide details:_____
   _____
8. Water PSI >30?.....__
   b. If 8a=2, simple modification required, provide details:_____
   _____

Questions 9 & 10 a. & b. Date and results of water analysis-Question removed

11. a. Clean, dry storage area?.....__
    Adequate storage is considered an enclosed area of at least 3ft by 3ft by 6ft, for storing cases of supplies.
    b. If 11a=2, simple modification required, provide details:_____

Continued, for Questions 4 – 13 (except where indicated otherwise): 0=No, not acceptable, 1=Approved as is, 2=Simple modification required (in the space provided, please detail modification(s) needed)

12. a. Presence of phone line in close proximity to bed? .....__

    b. If 12a=2, simple modification required, provide details:_____

    _____

13. a. Capability to dispose of chemicals pre- and post-treatment? .....__

    b. If 13a=2, simple modification required, provide details:_____

    _____

14. a. Are there plans to make the recommended modifications? .....__
    0=No, answer Q14b
    1=Yes, answer Q15
    8=Not applicable, no modifications required, skip to question 26.

    b. If patient does not plan to make modifications, what is the reason? .....__
    1=Too costly, 2=Too much hassle, 3=Changed mind about nocturnal study participation

    c. What type of currency is the estimated costs of modifications reported in? .....__
    1=American, 2=Canadian, 3=Australian

Estimated Costs of Home Modifications Required to Perform Home Hemodialysis (in your own country's currency)

Modifications (write in the modification needed)	**Estimated Cost of Modification*** (in whole dollars)	**Percent (%) to be covered by Patient**
Plumbing Modifications:		
15.	__ __ __ __	__ __ __
16.	__ __ __ __	__ __ __
Carpentry Modifications:		
17.	__ __ __ __	__ __ __
18.	__ __ __ __	__ __ __
Electrical Modifications:		
19.	__ __ __ __	__ __ __
20.	__ __ __ __	__ __ __
Other Modifications: (e.g., phone line)		
21.	__ __ __ __	__ __ __
22.	__ __ __ __	__ __ __
23.	__ __ __ __	__ __ __

* Includes costs paid for by grants from other sources.

24. a. Will any of the costs be covered by grants from other sources? .....__
    (0=No, skip to Q25, 1=Yes, complete Q24b)

    b. If yes, what amount of money is being provided by the sources? ($) .....__ __ __ __

25. Approximate date when modifications, if any, will be completed?
(Enter current date if no modifications will be required) ..... __ __/__ __ __ /__ __ __ __
(dd/mon/yyyy)

26. **FHN staff time spent doing home evaluation**

a. Time spent on travel (hours) ..... __ __.__ __

b. Time spent doing evaluation (hours) ..... __ __.__ __

200. Date this form completed (dd/mon/yyyy) ..... __ __/__ __ __ /__ __ __ __

201. Username of person completing this form ..... __ __ __ __ __ __ __

For Clinical Center Use Only:

202. Username of person entering this form: __ __ __ __ __ __ __

203. Date Entered: (dd/mon/yyyy) __ __/__ __ __ /__ __ __ __