Frequent Hemodialysis Network
NOCTURNAL TRIAL EVALUATION OF PATIENT AND CAREGIVER – FORM #102

Instructions: This form is to be completed by home training personnel during baseline for patients in the Nocturnal Trial.

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

PATIENT ASSESSMENT (For questions 4 – 10: 0=No, 1=Yes)

4. Does this patient have sufficient fine motor skills to connect to Luer locks on tubing? .....__

5. Does this patient have sufficient fine motor skills to turn dials on dialysis machine? .....__

6. Does this patient have sufficient visual acuity to read labels on dialysis machine? .....__

7. Can this patient read and understand the Nocturnal Dialysis teaching manual? .....__

8. Can this patient hear the telephone ringing or alarms from the dialysis machine without hearing aids? .....__

9. Does this patient appear to have sufficient motivation to complete training in home nocturnal dialysis?.....__

10. Does this patient appear to have sufficient stamina to complete training in home nocturnal dialysis?.....__

11. Patient's access and cannulation status .....__
    1 = This patient has a fistula or graft and is willing to try learn how to cannulate it
    2 = This patient has some other type of access
    3 = This patient has a fistula or graft and will not try to learn how to cannulate it

12. In the opinion of the person completing this form, is this patient capable of performing the necessary procedures to conduct his/her dialysis at home if randomized to the nocturnal arm of the FHN Trial? (0=No, 1=Yes) .....__

13. Patient monitoring plan.....__
    0 = A person who lives in this patient's apartment building will listen in via baby monitor
    1 = The patient will have remote monitoring
    2 = There is a partner living in the home who is willing to help the patient
    3 = Both of the above
    4 = Neither of the above *(note: this is an exclusion)*

See page 2 for caregiver assessment.

CAREGIVER ASSESSMENT: (For questions 14–18: 0=No, 1=Yes)

14. Is there a caregiver who is willing to assist with the items listed in questions 4 - 8?.....__
If response to Q14=No, skip to Q21;
If Yes, complete questions 15-18.

15. What is the relationship of this caregiver to the patient?.....__
1 = Spouse
2 = Significant other
3 = Child
4 = Parent
5 = Other (please specify) _____-

16. Is the caregiver accepting of having home hemodialysis equipment in the house? .....__

Caregiver questions with no home monitoring:

17. Does the caregiver appear to have sufficient motivation to complete training in home nocturnal dialysis?.....__

18. Does the caregiver appear to have sufficient stamina to complete training in home nocturnal dialysis?.....__

19. Patient's access and cannulation caregiver status: .....__
1=This patient has a fistula or graft and the caregiver is willing to try learn how to cannulate it.
2=This patient has some other type of access and the caregiver is willing to try learn how to cannulate it.
3=This patient has a fistula or graft and the caregiver will not try to learn how to cannulate it.
4=This patient has some other type of access and the caregiver is not willing to try to learn how to cannulate it or hook it up.

20. In the opinion of the person completing this form, is the caregiver capable of performing the necessary procedures to conduct the patient's dialysis at home if randomized to the nocturnal arm of the FHN Trial? (0=No, 1=Yes) .....__

NOTE: Answering 'No' to questions 12 AND 20 is an exclusion;
and answering 'No' to questions 12 AND 14 is an exclusion.

Time spent on patient evaluation

21. a. Physician hours spent doing evaluation..... __ __ __.__ __

b. Physician hours spent on travel..... __ __.__ __

22. a. Nurse hours spent doing evaluation..... __ __ __.__ __

b. Nurse hours spent on travel..... __ __.__ __

23. a. Social worker hours spent doing evaluation ..... __ __ __.__ __

b. Social worker hours spent on travel..... __ __.__ __

24. a. Dietitian hours spent doing evaluation ..... __ __ __.__ __

b. Dietitian hours spent on travel ..... __ __.__ __

25. a. Other personnel hours spent doing evaluation..... __ __ __.__ __

b. Other personnel hours spent on travel ..... __ __.__ __

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) __ __/__ __ __ /__ __ __ __