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Frequent Hemodialysis Network
ACCESS USED FOR CHRONIC HEMODIALYSIS - FORM 271

Instructions:

Trial: This form is completed at baseline and whenever the patient's access currently being used for chronic hemodialysis changes.

Extended Follow-up Study: Complete this form at time of final Extended Follow-up Study visit to identify what access is currently being used (even if it is the same access used throughout the trial).

1. Participant ID # 2. Alpha Code

4. What is the access that the patient is currently using for chronic hemodialysis? ..... __
   1=AV fistula
   2=AV graft *(note: if any part of an access is a graft, then it is considered a graft)*
   3=Tunneled catheter
   4=Non-tunneled catheter *(note: use of non-tunneled catheter in baseline is an exclusion)*

5. Date access (identified in Q4) was placed? (dd/mon/yyyy). ..... __ __/__ __ __ /__ __ __ __
   (If this is the initial baseline access and placement date is unknown, use the date of the first known use)

For Grafts or Fistulas:

6. a. Position ..... __
   1=Forearm 3=Leg 8=Not applicable
   2=Upperarm 4=Chest (*be sure to complete Q7*)

   b. Side (1=Right, 2= Left, 8=Not applicable) ..... __

For Tunneled Catheters:

7. Location of tunneled catheter: ..... __
   0=None 5=Right femoral 9=Right external jugular
   1=Right internal jugular 6=Left femoral
   2=Left internal jugular 7=Left external jugular
   3=Right subclavian 8=Right translumbar inferior vena cava
   4=Left subclavian (*if other codes are needed, email fhn-dcc*)

8. Date that access first used for chronic HD therapy: (mon/yyyy) ..... __ __ __/__ __ __ __
   (If this access was in place before the patient was enrolled in baseline and the placement date is unknown, use the date of the first known use.)

9. Does this patient have a second, different type of access that has been placed but is not currently being used? ..... __
   0=No 2=Yes, a fistula
   1=Yes, a graft 3=Yes, a catheter

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

201. Username of person reviewing completeness of this form ..... __ __ __ __ __ __ __

For Clinical Center Use Only:

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

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