Frequent Hemodialysis Network
ATTENDANCE AT IN-CENTER DIALYSIS SESSIONS - FORM#275

This form is completed during follow-up for all Daily Trial patients (and those in the Nocturnal Trial who are receiving dialysis in-center. Use Form 279 for Nocturnal Trial patients dialyzing at home). Form 275 is to be completed by the study coordinator or dialysis unit technician at the start of each calendar month following randomization in order to document missed dialysis treatments during the prior calendar month. Do not count those treatments completed for ultrafiltration only.

1. Participant ID # | 2. Alpha Code | 3a. Visit Type | 3b. Visit Number (of the calendar month listed below)

4. Indicate calendar month to which this form applies: ..... (mon/yyyy): __ __ __ / __ __ __ __

5. Did this patient avoid continual care of your FHN hemodialysis unit through the calendar month for any of the reasons listed below: (For questions 5a-d: 0=No, 1=Yes)

   a. Patient was admitted to a rehabilitation unit or nursing home.....__

   b. Patient was hospitalized on some of the days that patient should have been dialyzed at your unit.....__
   (Be sure to fill out hospitalization forms 302 and 303.)

   c. Patient was out of town part of the time .....__

   d. Patient was being cared for by some other dialysis unit than yours for some other reason .....__

For Questions 6-8: EXCLUDE the time that the patient was not under the care of the FHN dialysis unit:

6. What was the number of treatments that the patient should have had at your dialysis unit under the protocol ?.....__ __
(Do not include those treatments completed for ultrafiltration only)

7. How many treatments at your unit were missed during the designated calendar month?..__ __

8. How many treatments did the patient actually have at your unit`?.....__ __
(Do not include those treatments completed for ultrafiltration only)

Note: The responses to questions 7 and 8 should add up to the response in question 6.

200. Date 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) __ __/__ __ __ /__ __ __ __