Frequent Hemodialysis Network
COMPLETION OF NOCTURNAL v3.0 HOME DIALYSIS SESSIONS - FORM#279

This form is used for patients randomized to the Nocturnal Trial who are dialyzing at home. (During the end of the randomization month and the first calendar months following randomization, while the patient is still in training, use Form 275 to document the in-center dialysis sessions the patient attends.) Once the patient starts dialyzing at home, this form is to be completed at the start of each calendar month, in order to document held and missed dialysis treatments during the prior calendar month.

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): __ __ __ / __ __ __ __

Patient potential for doing home hemodialysis throughout the calendar month:

5. If the patient was unable to do home dialysis for part of the month, answer yes to the appropriate reason below. (For questions 5a-d: 0=No, 1=Yes)

   a. (For the one month in which part of the month falls prior to the first time the patient dialyzes at home) The patient's training was not yet complete: .....__

   b. The patient spent part of the month in a rehabilitation unit or nursing home:.....__

   c. The patient was hospitalized at some of the times that patient should have been dialyzing at home .....__
   (Be sure to fill out hospitalization forms 302 and 303.)

   d. The patient was out of town part of the time: .....__

For Questions 6-8: <u>EXCLUDE</u> the time when the patient could not have done home dialysis due to one of the four major reasons listed above.

6. What number of treatments should the patient have had at home? .....__ __

7. How many home treatments were missed during the designated month? .....__ __
   Include treatments missed due to non compliance or problems with health, water, electricity, dialyzer, etc.

8. How many home treatments did the patient complete during the designated month? .....__ __

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

For Nocturnal (6x/week) Only

9. How many of the home treatments were less than four hours long? Enter 0 for none and the count (1,2,3…) for any number one or higher .....__ __

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