FIND Medical Record Review

Barcode and Participant ID

Study Coordinator ID _____

Date of review (*MM/DD/YYYY*) __ __ | __ __ | __ __ __ __

Instruction to record abstractor: During review of the medical record(s), please review the Medical Questionnaire (Form 01), since it may be necessary to add or correct some data on the questionnaire (e.g., medicines or date of onset of diabetes or dialysis).

RECORD TYPE

1. Indicate type of record(s) reviewed (*Mark all that apply*).
   - ☐ Dialysis unit
   - ☐ Primary care (*Including records from the endocrinologist and/or nephrologist*)
   - ☐ Hospital
   - ☐ Other _____

PARTICIPANT INFORMATION

2. **Name**: _____
   Last *First* *Middle* *Maiden*
3. **Birth date** (*MM/DD/YYYY*): __ __ | __ __ | __ __ __ __
4. **Sex**: ☐ Male ☐ Female

Barcode and Participant ID	

KIDNEY DISEASE

Kidney Disease

5. **Is the level of urinary protein/albumin recorded in the record**?
   □No □Yes
   If **Yes**, then specify the following (*Mark the maximum value only*):

		Protein excretion rate		P/C ratio		Albumin excretion rate		A/C ratio
a.	□	<50 mg/24h	**or**	<0.15 mg/mg	**or**	<30 mg/24h	**or**	<0.03 mg/mg
b.	□	≥50 mg/24h	**or**	≥0.15 mg/mg	**or**	≥30 mg/24h	**or**	≥0.03 mg/mg
c.	□	≥500 mg/24h	**or**	≥0.5 mg/mg	**or**	≥300 mg/24h	**or**	≥0.3 mg/mg
d.	□	≥1.0 g/24h	**or**	≥1.0 mg/mg	**or**	≥1.0 g/24h	**or**	≥1.0 mg/mg
e.	□	≥3.0 g/24h	**or**	≥3.0 mg/mg	**or**	≥3.0 g/24h	**or**	≥3.0 mg/mg
f.	□	Nephrotic (3.0g – 3.5g)						
g.	□	None						

   If **a**, record date of **LAST** value (*MM/DD/YYYY*): __ __ | __ __ | __ __ __ __
   Also record whether subject is receiving antihypertensive therapy at **LAST** value: □No □Yes
   HIGHEST value: □No □Yes

   If **e**, record date of **FIRST** value at this level (*MM/DD/YYYY*): __ __ | __ __ | __ __ __ __

Equivalent Measures of Urinary Albumin Excretion		
30 mg/24h	=	20 µg/min
300 mg/24h	=	200 µg/min

   If the excretion reported above is a ratio, record the urine protein (albumin) and creatinine concentrations:

   Urine protein (*mg/l*) __ __ __ __ __ . __ **or** Urine albumin (*mg/l*) __ __ __ __ __ . __

   Urine creatinine (*g/l*) __ . __ __

6. **Is the participant receiving chronic renal replacement therapy**?
   □ No □Yes If **Yes**, record the date of onset (*MM/DD/YYYY*): __ __ | __ __ | __ __ __ __
   □Yes AA MALD with Nephropathy but no DM

   If **No**, record the **HIGHEST** serum creatinine concentration (*mg/dl*): __ __ . __

   Date of **HIGHEST** serum creatinine concentration (*MM/DD/YYYY*): __ __ | __ __ | __ __ __ __

7. **Primary cause of kidney failure / renal insufficiency (*Mark all that apply*)**?
   □Diabetes
   □Hypertension
   □ IgA nephropathy
   □ Membranous glomerulonephritis
   □Focal glomerulosclerosis
   □Other _____
   □Polycystic kidney disease
   □Lupus nephritis
   □Kidney cancer
   □Obstruction
   □Don't know
   □None

Barcode and Participant ID	

8. **Is a kidney biopsy recorded in the record**?
   □No □Yes If **Yes**, record the biopsy date (*MM/DD/*YYYY): __ __ | __ __ | __ __ __ __

   If **Yes**, specify methods of evaluation (*Mark all that apply*).
   □Light microscopy □Electron microscopy □Immunofluorescence

   Also specify the histologic findings (*Mark all that apply*).
   □Increased nodular mesangial matrix.
   □Increased diffuse mesangial matrix.
   □Thickened glomerular basement membrane.
   □Arterial hyalinization.
   □Arteriolar hyalinization.
   □Mesangial immunoglobulin or paraprotein deposits by immunofluorescence.
   □Amyloid deposits by Congo red staining or electron microscopy.
   □Electron dense deposits within the glomerular basement membrane or glomerular capillary subendothelial space.
   □ Non-Diabetic Pahtological Diagnosis

HISTORY OF DIABETES

9. **Has a diagnosis of diabetes been made**?
   □ No □ Yes
   If Yes, record the source of the diagnosis (*Mark all that apply*):

   □Fasting plasma glucose ≥ 126 mg/dl (or venous whole blood glucose ≥ 110 mg/dl or capillary whole blood glucose ≥ 110 mg/dl) *

   □ Random plasma glucose ≥ 200 mg/dl (or venous whole blood glucose ≥ 180 mg/dl or capillary whole blood glucose ≥ 200 mg/dl) * and symptoms (*polyuria, polydipsia, polyphagia*).

   □ Two-hour post-load plasma glucose ≥ 200 mg/dl (or venous whole blood glucose ≥ 180 mg/dl or capillary whole blood glucose ≥ 200 mg/dl) * (*OGTT*).

   □ Clinical diagnosis without documented plasma glucose concentration.

   Record the earliest date of diagnosis (*MM/DD/YYYY*): __ __ | __ __ | __ __ __ __

   *The measurement of glucose in serum is discouraged by the WHO (World Health Organization). Unless the red cells are immediately removed to prevent glycolysis, serum samples should not be used for diagnosing diabetes. If only serum glucose values are found in the record, however, they should be interpreted as if they were plasma values.

10. **Is a diagnosis of diabetic ketoacidosis or diabetic coma recorded in the record**?
    □No □Yes

Barcode and Participant ID	

DIABETIC EYE DISEASE

11. **Is a diagnosis of diabetic retinopathy recorded in the record**?

☐No ☐Yes

If **Yes**, specify the severity of the retinopathy (*Mark all that apply*).

☐Background retinopathy
☐Pre-proliferative retinopathy
☐Proliferative retinopathy
☐Vitreous hemorrhage
☐Macular edema
☐Photocoagulation therapy