



Attention - DO NOT enter patient data on this form if the header does not contain *preprinted* HALT PKD ID number, clinical center ID, and visit number.

Participant ID: _____ *haltid* Clinical Center: _____ *clinic* Date of Report ____/____/____
visit:

Missing Data Codes: A-Participant Refused B-Reading Not Possible C-Institutional Error

HOSPITALIZATION FORM

Form # 30

This form is to be completed by designated personnel for any in-patient hospitalization. All hospitalizations, elective and non-elective, are immediately reportable as SAEs. Sites must obtain the discharge summary report to keep on file (all identifying information obliterated). Use event codes described in the Manual of Procedures.

1. Date study personnel were informed of hospitalization: ____/____/____
hpm hpd hpy

2. Date of Hospital Admission: ____/____/____ Date of Discharge: ____/____/____
hpam hpad hpay hpdm hpdd hpyd

3. Was the admission elective? *hpadel* 1 Yes 0 No

4. Did the participant die in the hospital? *hpdie* 1 Yes 0 No (If Yes, complete Death Notification Form 31)

5. Primary Reason for Hospitalization: Event Category *evtcode* _____ Event term *text* _____

6. Secondary Event/Complications, if any: *evtcomp* _____

7. Was renal surgery performed? *kdsbyn* 1 Yes 0 No (If Yes, comment below)

8. Comments: *hpmed* _____

OPTIONAL TRACKING INFORMATION FOR MEDICAL RECORDS (Not data-entered)

Name of Institution: _____ City: _____ State: _____
Date Requested: ____/____/____ Contact: _____ Date Received: ____/____/____
Comments: _____

HALT PKD staff member completing this form: _____ Date: ____/____/____
cmidnum cdm Month cdd Day cdy Year

Reviewed by Study Investigator: _____ Date: ____/____/____
(signature required) pism Month pisd Day pisy Year

Data Entry Status: Please check to indicate that the above information has been entered

Primary Entered by: _____ Date: ____/____/____
deidnum dem Month ded Day dey Year

Secondary Entered by: _____ Date ____/____/____