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:** ___/___/___
month *dvm* day *dvd* year *dvy*

visit: **___Form was not completed** *misfrm*

PARTICIPANT NEXT TO LAST VISIT QUESTIONNAIRE

Form # 131

Dear Participant,

During your visit today, we ask that you provide us with the answers to the questions below. This information will assist the HALT-PKD team to safely transition your clinical care back to your local physician when the study ends. Your study coordinator will assist you to complete this questionnaire.

1) During today's visit, did you complete the HALT-PKD study FORM #2- "Contact Information Form"? *form2Completed*	1 ☐ Yes	0 ☐ No	
2) Do you have a PCP or nephrologist identified for the HALT-PKD team to transition your care to in six months? *pcpneph*	1 ☐ Yes	0 ☐ No	3 ☐ Unsure
2a) If no or unsure, **do you have access to an alternative care center or clinic?** Please provide that contact information to your coordinator. *clinic*	1 ☐ Yes	0 ☐ No	3 ☐ Unsure
3) When the study comes to an end, will you have established insurance, Medicaid or Medicare coverage? *insurance*	1 ☐ Yes	0 ☐ No	3 ☐ Unsure
3a) If no or unsure, **do you plan to apply for Medicaid or Medicare coverage?** If so, please start the application process within the next two weeks. *applyCoverage*	1 ☐ Yes	0 ☐ No	3 ☐ Unsure
4) Once the study results are released, your HALT PKD investigator will send you, and the physician you identified on Form #2, a letter containing your study information gathered over the course of the study. This letter will provide your lab results (kidney function-eGFR), radiology results (total kidney volume on MRI-Study A only), current stage of kidney disease, blood pressure measurement, and your study treatment assignment (either telmisartan or placebo).	1 ☐ participant notified of planned release of study information. *ptnotified*		
5) Please identify the physician or designated provider that is to receive the final study letter. *provider* **Please contact the study staff if you change your local physician and provide updated contact information.	1 ☐ PCP/PA/CRNP (Form #2 item 10) ***OR*** 2 ☐ Nephrologist (Form #2 item 11)		
6) How would you like us to send the final study letter to you? *notificationMethod* **Please contact the study staff if you relocate and provide updated contact information.	1 ☐ email account *identify primary email account on Form 2 only* 2 ☐ certified mail		

COMMENTS: *comments*

_____

_____

_____

****PARTICIPANT NAME**: _____

****PARTICIPANT SIGNATURE**: _____

*****These form fields are excluded from entry into the HALT-PKD database to protect confidentiality.***

COORDINATOR NAME: _____

****

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

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