

### HEMO Study Form 35. Supplement Distribution

Complete this form when dispensing vitamins/minerals or enteral supplements. This information will be entered into the study database.

- 1. Patient Identification Number ..... \_\_\_\_\_
- 2. Patient Name Code ..... \_\_\_\_\_
- 3. Visit Date ..... \_\_\_\_/\_\_\_\_/\_\_\_\_
- 4. Visit Type ..... \_\_\_\_\_
- 5. Month Number ..... \_\_\_\_\_
- 6. Product(s) dispensed:
  - a. Nephro-vite (# of bottles) ..... \_\_\_\_\_
  - b. Skip this item number ..... \_\_\_\_\_
  - c. Nepro (# of cans) ..... \_\_\_\_\_
  - d. Suplena (# of cans) ..... \_\_\_\_\_
  - e. Promod (# of cans) ..... \_\_\_\_\_
  - f. Polycose liquid (# of cans) ..... \_\_\_\_\_
  - g. Polycose powder (# of cans) ..... \_\_\_\_\_
  - h. Glucerna (# of cans) ..... \_\_\_\_\_
  - i. Other supplement: (# of cans) ..... \_\_\_\_\_
  - j. Glucerna OS (# of cans) ..... \_\_\_\_\_

For products 6c-6h and 6j, what triggered the need for a supplement? (0=no, 1=yes)

- 7. Action item: declining serum albumin ..... \_\_\_\_\_
- 8. Action item: undesired weight loss ..... \_\_\_\_\_
- 9. Other (specify) \_\_\_\_\_
- 201. Date this form completed ..... \_\_\_\_/\_\_\_\_/\_\_\_\_
- 202. Certification number of person completing this form ..... \_\_\_\_\_

<p>Clinical Center Use Only</p> <p>Data Form Entered ____/____/____</p> <p>Person Entering this Form _____</p>
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