# Modification of Diet in Renal Disease Study
## ABBREVIATED FOLLOW-UP FORM

This form is to be used every four months for patients reaching a stop point who do not enter Study C.

The Study Coordinator should be responsible for completing the form. Be sure to complete the necessary forms for blood work, dietary review and GFR as explained in the instructions.

| QUESTION # | INSTRUCTIONS |
|---|---|
| 4. | c. Visit Number. The patient's abbreviated visit should be numbered as if you would have been seeing the patient monthly. For example, stop point visits will be numbered A 4.0, A 8.0, A 12.0 or A 16.0 etc. The abbreviated visits after a stop point should fall at the regularly scheduled follow up visit 4, 8, 12 etc... If a stop point is reached at F3, the first abbreviated visit would be one month later and be labeled A4. The next would be 4 months after that and labelled A8. If a stop point is reached at F5 then the first abbreviated visit would be 3 months later and labelled A8. The appointment schedule should thus remain helpful. However, rather than a 15 day window you can expand to ± 30 days from the target. Thus, refer to target date, not first and last possible dates. |
| 5. | If the visit is missed, skip to Item 11. You may still obtain information for 11-13. If the patient could not be contacted or the data for 11-13 is not known, enter a blank. |
| 6. | The patient's actual body weight should be recorded in kilograms to the nearest tenth. It should be measured and recorded twice by any team member. The dietitian is responsible for completing an Anthropometry Form. The Datalex range is 40 to 130 kg. |
| 7. | Enter the code which best describes the degree of edema. |
| 8. | Referring to the drug list, complete the first space with the drug code if the patient is taking the medication presently.<br><br>Complete the second and third parts to the item as thoroughly as possible. Mark the amount of the drug being taken in the units which have been specified and the number of times per day. PRN drugs should be given a code of 'Times/Day' of 99. See instructions for Form 5, page 2.76.1, for description of frequency codes.<br><br>Medications altered <u>at</u> this visit should be recorded here now, not at the next visit. |
| 9. | If the patient has had any illnesses since the last visit for which they were hospitalized, enter a 1. If not, enter a 2. |
| 10. | If the patient does not smoke, enter 00.00. |

Modification of Diet in Renal Disease Study
ABBREVIATED FOLLOW-UP FORM

| QUESTION # | INSTRUCTIONS |
|---|---|
| 11. | a. If the patient has begun dialysis, enter a 1. If not, enter a 2. |
| | b. Enter the date the patient began on dialysis. |
| | c. Enter the code describing the type of dialysis the patient is on. |
| 12. | a. If the patient has had a transplant, enter a 1. If not, enter a 2. |
| | b. Enter the date of the transplant. |
| 13. | Enter diets patient is currently following. |
| 14., 15. | If the visit was missed, still complete with any amount of time spent in between visits. If no time was spent, enter 0. |

MDRD

# Modification of Diet in Renal Disease Study
## Abbreviated Follow-Up Form

This form is to be completed every four months for patients who have reached a stop point and do not enter Study C.

An anthropometry form should be completed by the study dietitian. Blood work should be done and sample sent to the central lab for serum creatinine (except on dialysis or transplant patients), albumin, and transferrin.
A GFR should be done (except on dialysis or transplant patients). Dietary recall and a 24-hour urine should be done as well.

FORM # ..... 1 2

1. Patient Identification Number ..... ___ ___ ___ ___ ___ ___
2. Patient Name Code ..... ___ ___ ___ ___
3. Clinical Center ..... ___ ___
4. a. Date of this follow-up visit (Enter target date from appointment schedule if missed) ..... ___ ___/___ ___/___ ___

   b. Visit Type ..... A

   c. Visit Number ..... ___ ___ . ___
5. a. Was this visit missed? (outside window, not held) (1 = yes, 2 = no) ..... ___

   **If yes,**

   b. Reason visit was missed ..... ___ ___

   1 = Illness
   2 = Hospitalization
   3 = Personal family business
   4 = Work related business
   5 = Vacation
   6 = Forgot
   7 = Patient refused
   8 = Weather
   9 = Could not contact
   10 = Moved
   11 = Other (Specify) (_____)
   12 = Unknown

**If the visit was missed, skip to item 11.**

**If the visit was missed due to reason 2, complete the Unscheduled Attention Form (Form #10).**

**Physical Examination**

(To be provided by the dietitian)

6. Actual body weight (kg) 1.) ..... ___ ___ ___ . ___
   2.) ..... ___ ___ ___ . ___

**Complete Blood Pressure Form.**

7. Edema ..... ___

   0 = Absent
   1 = 1+
   2 = 2+
   3 = 3+
   4 = 4+
   9 = Not done

# Modification of Diet in Renal Disease Study
# Abbreviated Follow-Up Form

## Drugs/Nutritional Supplements

8. **Referring to the Drug list in the Manual of Operations, list all drugs the patient is currently taking. Pay careful attention to units.**

| | Code Number | Dosage | Times/Day |
|---|---|---|---|
| a. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| b. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| c. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| d. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| e. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| f. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| g. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| h. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| i. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| j. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| k. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| l. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| m. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| n. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |
| o. | ___ ___ ___ ___ ___ | ___ ___ ___ ___ ___ ___ | ___ ___ |

9. Has the patient had any new illnesses for which he/she was hospitalized since the last visit? (1 = yes, 2 = no) ..... ___

**If yes, complete the Unscheduled Attention From (Form #10)**

10. How many packs per day does the patient smoke? ..... ___ ___ . ___ ___

11. a. Has the patient begun dialysis? ( 1 = yes, 2 = no ) ..... ___

    b. Date dialysis began ..... ___ ___/___ ___/___ ___

    c. Type of dialysis ..... ___

    1 = Hemodialysis
    2 = Home hemo
    3 = CAPD
    4 = CCPD
    5 = IPD
    9 = Unknown

12. a. Has patient had a transplant? (1 = yes, 2 = no ) ..... ___

    b. Date of transplant ..... ___ ___/___ ___/___ ___

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13. Is the patient currently following any special diet therapy? (1 = yes, 2 = no)
    a. Very low protein (with supplements)..... ___
    b. Low protein..... ___
    c. Low salt..... ___
    d. Low calorie..... ___
    e. Other (20 characters maximum)(_____)..... ___

14. How much time has the dietitian spent in patient care related activities preparing for and at this visit? (To be provided by the dietitian.)
    (hh:mm)..... ___ ___:___ ___

15. How much time has the physician spent in patient care related activities preparing for and at this visit? (To be provided by the physician.)
    (hh:mm)..... ___ ___:___ ___

101. Date this form completed..... ___ ___/___ ___/___ ___

102. Certification number of person filling out this form..... ___ ___ ___ ___ ___

103. Date form entered..... ___ ___/___ ___/___ ___

104. Certification number of data entry person..... ___ ___ ___ ___ ___

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Retain a copy of this form for your files. Send the original to the MDRD Study Data Coordinating Center. Please use MDRD Study mailing labels:

MDRD Study Data Coordinating Center
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The Cleveland Clinic Foundation
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