

**Modification of Diet in Renal Disease Study  
ANNUAL FOLLOW-UP INFORMATION FORM**

This form is to be completed by the Study Coordinator at each annual follow-up visit (F-12, etc.) in addition to the monthly visit form. Directions for all questions can be found in the Form #04 instructions. For Study F and stop point patients complete annually - every 3rd visit and do not complete items 17 or 18 for these patients.

If the times or costs in item 16a-f are zero, enter zeros. If the times or costs are unknown, enter all 9's.

QUESTION #

INSTRUCTIONS

9-10.

The following is the list of income categories:

- |                     |                     |
|---------------------|---------------------|
| 1 = < \$7,500       | 4 = 25,000 - 39,999 |
| 2 = 7,500 - 14,999  | 5 = 40,000 - 49,999 |
| 3 = 15,000 - 24,999 | 6 = 50,000 - 74,999 |
|                     | 7 = ≥ 75,000        |
|                     | 9 = unknown         |

15.

Height should be measured by the dietitian twice and recorded here. Standard body weight will not be recalculated.

17-18.

For Study F and Stop Point patients these questions may be skipped.

For DCC Use Only  
Rev. 2 10/15/88

E \_\_\_  
V \_\_\_  
T \_\_\_

Form # 13  
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### Modification of Diet in Renal Disease Study Annual Follow-up Information Form

This form is to be completed at Follow-Up Visits 12, 24, 36 and 48 for all study participants in Studies A, B, and C in addition to routine forms for the visit. Also complete the form annually for Study F and Stop point patients.

FORM # ..... 13

1. Patient Identification Number.....
2. Patient Name Code.....
3. Clinical Center.....
4. a. Date of visit..... / /
- b. Visit Type.....
- c. Visit Number.....
5. Education.....
 

1 = College graduate with professional training	5 = Completed 10-11 years of school
2 = College graduate	6 = Completed 7-9 years of school
3 = At least one year of college	7 = Completed <7 years of school
4 = High school graduate	9 = Unknown
6. Occupation. (Enter a number, 1-9, from list for Form 4. If not presently employed, please indicate most recent occupation.).....
7. Is the patient a full-time homemaker? (1 = yes, 2 = no).....
8. a. Current Employment Status.....
 

1 = Full time	6 = Retired due to disability
2 = Part time	7 = Other (20 characters maximum)
3 = Unemployed not due to disability	(.....)
4 = Unemployed due to disability	9 = Unknown
5 = Retired not due to disability	
- b. If unemployed due to disability, is it a renal disability? (1 = yes, 2 = no).....
- c. If working part time only, is this due to a renal disability? (1 = yes, 2 = no).....
- d. If working full or part time, how many days in the past year did the patient miss work due to illness?.....
- e. If working full or part time, what is the patient's current wage rate?..... \$.....
- f. Is this rate hourly, weekly, or monthly? (H = hourly, W = weekly, M = monthly).....
9. What is the patient's gross annual income presently? (Enter the code for the appropriate income category from the instructions).....
10. a. What is the total household gross yearly income? (Enter the code for the appropriate income category from the instructions).....
- b. How many people are supported, in part or whole, from the total household income?.....

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11. Does the patient currently smoke cigars or pipes? (1 = yes, 2 = no)..... \_\_\_\_\_
12. a. Religion..... \_\_\_\_\_  
1 = Catholic  
2 = Protestant  
3 = Jewish  
4 = Other (20 characters maximum)  
( \_\_\_\_\_ )  
5 = None  
6 = Unknown
- b. Does the patient feel that his or her religious practices influence his or her diet?  
(1 = yes, 2 = no)..... \_\_\_\_\_  
If yes, specify \_\_\_\_\_
13. Marital Status..... \_\_\_\_\_  
1 = Single  
2 = Married  
3 = Separated  
4 = Divorced  
5 = Widowed  
9 = Unknown
14. Living Arrangements (1 = yes, 2 = no)  
a. alone..... \_\_\_\_\_  
b. with spouse..... \_\_\_\_\_  
c. with children..... \_\_\_\_\_  
d. with parents..... \_\_\_\_\_  
e. with other relatives..... \_\_\_\_\_  
f. with friends..... \_\_\_\_\_  
(To be provided by the dietitian)
15. Height (cm) 1.)..... \_\_\_\_\_  
2.)..... \_\_\_\_\_
16. a. Estimated average round trip travel time to clinic for each visit (hh:mm).. \_\_\_\_\_ : \_\_\_\_\_  
b. Estimated average lost work time for each visit (hh:mm)..... \_\_\_\_\_ : \_\_\_\_\_  
c. Estimated average round trip travel cost for each visit to clinic..... \$ \_\_\_\_\_ . \_\_\_\_\_  
d. Average amount of lost wages per clinic visit..... \$ \_\_\_\_\_ . \_\_\_\_\_  
e. Average amount of child care costs per clinic visit..... \$ \_\_\_\_\_ . \_\_\_\_\_  
f. Average other costs per clinic visit..... \$ \_\_\_\_\_ . \_\_\_\_\_
17. a. Suppose it is found conclusively that this diet will delay the onset of kidney failure requiring kidney dialysis or transplantation. If the government were to pay for the costs of this treatment, much like the case in this trial, does the patient say he or she would recommend dietary treatment to a close friend in a similar situation?  
(1 = yes, 2 = no)..... \_\_\_\_\_
- If yes,  
b. How strongly would the therapy be recommended?..... \_\_\_\_\_  
1 = Very strongly without reservation  
2 = Very strongly with reservation  
3 = Moderately without reservation  
4 = Moderately with reservation

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17. (Continued)
- c. Suppose the cost of the treatment were \$50.00 per month, not covered by insurance. Would the patient still recommend diet therapy to his or her friend? (1 = yes, 2 = no).....
  - d. Suppose the cost were \$100.00 per month. Would the patient still recommend diet therapy to his or her friend? (1 = yes, 2 = no).....
18. Suppose it is found conclusively that this diet will delay the onset of kidney failure requiring dialysis or transplantation, and the diet, physician services, medical care, counselling and food/drug supplements may cost up to \$300 per month. How much would the patient be willing to pay out of pocket (not covered by insurance) each month to continue the diet?  
(Start with the highest amount and ask for a yes/no response. Continue until the first yes answer is given.)(1= yes, 2=no)
- a. \$300 per month.....
  - b. \$250 per month.....
  - c. \$200 per month.....
  - d. \$150 per month.....
  - e. \$100 per month.....
  - f. \$50 per month.....
  - g. \$25 per month.....
  - h. \$10 per month.....
  - i. Unknown.....
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  
Department of Biostatistics & Epidemiology  
The Cleveland Clinic Foundation  
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