# Modification of Diet in Renal Disease Study
# CENTRAL LABORATORY BLOOD/URINE MAILING FORM

This form is to be completed by the MDRD technician or study coordinator every month for the 24-hour urine collected (and in addition every second month for blood tests).

This form should be completed as blood and urine is required, whether samples are collected or not. See Manual of Operations, Chapter 3, for complete discussion of drawing blood, processing, packaging and shipment of containers.

Include a copy of this form, with the samples being shipped to the Central Biochemistry Lab. Complete, enter and transmit the form in the usual manner. Complete the form for all Required Procedures whether they were done or not.

QUESTION # INSTRUCTIONS

4. b. Visit type - B is baseline, F is follow-up, A is abbreviated follow-up for visits every 4th month after a stop point has been reached, and P should be used when blood work is being done at the special 2 week visit after a stop point. X is used for Study F blood work. Visit type K is for all Study C post stop point visits.

c. Visit numbers are sequential as follows:

| | | | |
|---|---|---|---|
| 0.0 = | Baseline Visit 0 | | |
| 1.0 = | Baseline Visit 1 | 1.0 = | Follow-up visit 1 |
| 2.0 = | Baseline Visit 2 | 2.0 = | Follow-up visit 2 |
| 3.0 = | Baseline Visit 3 | 3.0 = | Follow-up visit 3 |
| | | 4.0 = | Follow-up visit 4 (etc.) |

For blood work right after a stop point use 1.0 here.

If a second blood sample is sent after B3 for repeat albumin, label 3.9.

6. Indicate status of each applicable collection.

a-b. A complete collection is defined as being between 23 1/2 and 24 1/2 hours. If it is not complete enter 3 and do not send samples to the lab. It is important to explain the reason why the blood or urine was not done (short collection, incomplete or spilled, patient fainted, or whatever the reason may be).

7. b. If the number of hours is zero, enter 0. It if is unknown, enter 99.

d. Indicate the reason blood work was done. If due to action item, the form must indicate which tests need to be done by the CBL. This takes precedence over routine measures. The visit number alerts the CBL to which routine measures to do.

8. f. This question has been added.

For DCC Use Only
Rev. 5 10/4/90

E ___
V ___
T ___



MDRD

# Modification of Diet in Renal Disease Study
# Central Laboratory Blood/Urine Mailing Form

This form is to be completed every month for the 24-hour urine collected and every 2nd month for both blood and urine tests. Complete for all required tests.

FORM # ..... 17

1. Patient Identification Number ..... ___ ___ ___ ___ ___ ___
2. Patient Name Code ..... ___ ___ ___ ___
3. Clinical Center ..... ___ ___
4. a. Date form completed ..... ___ ___/ ___ ___/ ___ ___
   b. Visit Type ..... ___
   c. Visit Number ..... ___ ___ . ___
5. Type of Sample that should have been collected ..... ___
   1 = Blood
   2 = Urine
   3 = Both
6. a. Status of Blood Collection ..... ___
   1 = Blood collected
   2 = Blood not collected due to short-term illness
   3 = Blood not collected - other reason _____
   b. Status of Urine Collection ..... ___
   1 = Urine collected
   2 = Urine not collected due to short-term illness
   3 = Urine not collected - other reason _____
7. a. Date blood drawn ..... ___ ___/ ___ ___/ ___ ___
   b. How many hours was the patient fasting before blood was drawn? ..... ___ ___
   c. Were medications (NSAIDS, cimetidine, trimethorprim, cephalosporins) appropriately withheld 48 hours prior to the test? (1 = yes, 2 = no) ..... ___
   (If not taking any medications, answer 1 = yes.)
   d. Reason blood drawn ..... ___
   1 = Regularly scheduled
   2 = 1 week after stop point
   3 = Repeat B3 albumin for eligibility
   4 = Repeat due to action item
   specify: _____
   _____
   _____
   _____

# Modification of Diet in Renal Disease Study
# Central Laboratory Blood/Urine Mailing Form

8. a. Total volume of jug (urine + preservative) (ml) ..... ___ ___ ___ ___

   b. Volume of preservative alone ..... ___ ___ ___ ___

   c. Date urine collection completed ..... ___ ___/ ___ ___/ ___ ___

   d. Starting time (24-hour clock) ..... ___ ___ : ___ ___

   e. Ending time (24-hour clock) ..... ___ ___ : ___ ___

   f. Were medications withheld appropriately? (1 = yes, 2 = no) ..... ___
   (If not taking any medications, answer 1 = yes.)

9. a. Have samples been sent to the lab? (1 = yes, 2 = no) ..... ___

   b. Date sent to central laboratory for analysis ..... ___ ___/ ___ ___/ ___ ___

101. Certification number of person completing this form ..... ___ ___ ___ ___ ___

102. Date form entered ..... ___ ___/ ___ ___/ ___ ___

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

---

Retain a copy of this form for your files. Send the original to the MDRD Study GFR Central Lab. Please use MDRD Study mailing labels:

MDRD Central Laboratories
Desk A101
The Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, Ohio 44195-5042

---