Modification of Diet in Renal Disease Study
UNSCHEDULED MEDICAL ATTENTION FORM

This form is to be completed when a patient is hospitalized for any reason.

QUESTION #	INSTRUCTIONS
4.	b. Sequence Number: 1 = First of one or more visits to a physician or physicians occurring on this date by this patient. 2 = Second of two or more visits to a different physician or physicians occurring on this same date as previously noted on the first Unscheduled Medical Attention Form by this patient. 3 = Third of three or more visits etc....
5.	Keep this to these general categories. Phone consultation may be considered "other". As of 3/1/90, the answer to this should always be 5=hospitalization. No need to complete this form otherwise.
5a-d.	Identify dates and codes as they relate to hospital admission. The diagnoses and surgery codes are important. Do the very best you can to get the appropriate codes.
6.	Reason for Medical Attention: 1 = No problem, i.e., routine check-up to non-study physician. 2 = Mild, i.e., renewing drugs, blood pressure check, of non-emergency condition 3 = Moderate, i.e., required time off from work, interferred with normal daily activities and required attention. 4 = Severe, i.e., required hospitalization, cast-broken bones. 5 = Surgery required. 9 = not applicable
7b.	Indicate the total number of days the patient has been off the study diet. If the patient eventually reaches a stop, indicate the number of days up until the date of the stop point.
8.	The physician's name, and business address should be clearly PRINTED and entered into Datalex. HCFA will use this information when necessary to access financial information. PRINT LEGIBLY. The title should be abbreviations as follows: MD, PHD, DDS, RN, DO. Do not use Dr. as part of physician's first name. VA can be abbreviated. Left justify. Complete as much of the name as possible.

For DCC Use Only
Rev. 2 12/1/90

E ___
V ___
T ___

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This form is to be completed when a patient is hospitalized.

FORM # 1 0

1. Patient Identification Number ..... ___ ___ ___ ___ ___ ___
2. Patient Name Code ..... ___ ___ ___ ___
3. Clinical Center ..... ___ ___
4. a. Date of Medical Attention ..... ___ ___/ ___ ___/ ___ ___

   b. Sequence Number (1st, 2nd, 3rd visit in same day) ..... ___
5. Type of Attention ..... ___

   1 = Clinic visit
   2 = Visit to non-study physician
   3 = Emergency room
   4 = House call
   5 = Hospitalization
   6 = Other (_____)
   9 = Unknown

   If hospitalization,

   a. Date of admission ..... ___ ___/ ___ ___/ ___ ___

   b. Date of discharge ..... ___ ___/ ___ ___/ ___ ___

   c. Primary diagnosis (ICD-9) ..... ___ ___ ___ . ___

   d. Surgery code (ICD-9) ..... ___ ___ ___ . ___
6. Reason for Medical Attention

   For the following enter:

   1 = No problem
   2 = Mild
   3 = Moderate
   4 = Severe
   5 = Surgery required
   9 = Not applicable

   Related to:

   a. kidney disease ..... ___

   b. brain/nervous system ..... ___

   c. eyes/vision ..... ___

   d. ears/hearing ..... ___

   e. heart ..... ___

   f. vasculature ..... ___

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6. (Continued)
   g. lungs ..... ___
   h. liver ..... ___
   i. spleen/lymph ..... ___
   j. muscles ..... ___
   k. bones ..... ___
   l. joints ..... ___
   m. skin ..... ___
   n. gastrointestinal ..... ___
   o. gynecology ..... ___
   p. dentist ..... ___
   q. placement of vascular access ..... ___
   r. other(_____) ..... ___

7. a. Did patient go off study diet due to illness? (1 = yes, 2 = no) ..... ___
   b. Number of days patient was off diet ..... ___ ___ ___

8. a. Physician providing unscheduled care (must be entered)
   First Name ... ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
   Last Name ... ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
   Title ..... ___ ___ ___ ___

   b. Location of physician:
   Hospital ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
   Address ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
   City ..... ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
   State ..... ___ ___
   Zip Code ..... ___ ___ ___ ___ ___ - ___ ___ ___ ___

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Unscheduled Medical Attention Form

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

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

103. Physician's signature ..... _____

104. Certification number of physician ..... ___ ___ ___ ___ ___

105. Has form been signed by physician? (1 = yes, 2 = no) ..... ___

106. Date form entered..... ___ ___/ ___ ___/ ___ ___

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