Patient Name________________________________ DMMS ID#

Patient Soc. Sec. # ☐☐☐ - ☐☐ - ☐☐☐☐

Patient Medicare # ☐☐☐ - ☐☐ - ☐☐☐☐ - ☐☐

Confidential Report Medical Questionnaire (DMMS -Prospective)

First Dialysis Date (A6): mm dd yy

Study Start Date (A7): mm dd yy

Check box to left of item if unable to determine, and leave item (right) blank.

A. Patient and Facility Identification

1. **Abstractor Initials:**
2. **Date Completed:** mm dd yy

- 3. **Ethnicity :** ....
  1 - Hispanic Origin 2 - Not of Hispanic Origin
- 4. **Race:** ....
  1 - White 2 - Black 3 - Asian
  4 - Native American 5 - Other
- 5. **Patient's Zip Code:**
- 6. **Date of first regular dialysis <u>for chronic renal failure</u>:** (at least once weekly; regardless of setting). Please exclude intermittent dialysis treatments only for fluid overload or heart failure.
  mm dd yy
- 7. **Study Start Date (Date #A6 plus 60 days):**
  mm dd yy
  Please copy these dates from A6 and A7 to the upper hand right corner of each page
- 8. **Was date of earliest known dialysis - same as #A6?** .... **(i.e. were there no <u>intermittent</u> treatments prior to date at A6?)**
  1 - Yes 2 - No

➔ ***(If item 8 is "no," give earliest date):***

mm dd yy

9. Insurance (answer all that apply in both columns):

1 - Yes 2 - No

	in the month before date A6	at or near date A7
• a. Blue Cross/Blue Shield :	☐	☐
• b. Private (other than BC/BS):	☐	☐
• c. Medicare:	☐	☐
• if "no," is Medicare pending?		☐
• if "yes," is Medicare secondary?	☐	☐
• d. Medicaid:	☐	☐
• e. VA:	☐	☐
• f. Other:	☐	☐
• g. None:	☐	☐
• h. Enrolled in an HMO?	☐	☐

B. Patient History Within 10 Years Prior to Study Start Date (date A7)

- 1. **Primary cause of ESRD:** ....
  1 - Diabetes
  2 - Hypertension
  3 - Primary glomerulonephritis
  4 - Other
- 2. **Regular cigarette smoking status:** ....
  1 - Active (still smoking)
  2 - Former, stopped <1 year ago
  3 - Former, stopped >1 year ago
  4 - Smoker, current status unknown
  5 - Non Smoker

3. History of Coronary Heart Disease (CHD) or Coronary Artery Disease (CAD)

For a through g code 1 - Yes 2 - No 3 - Suspected

- a. Prior diagnosis of CHD/CAD: ....
- b. Angina: ....
- c. Myocardial infarction (MI): ....
- d. Bypass surgery (CABG): ....
- e. Coronary angioplasty (PTCA): ....
- f. Coronary angiography: ....
  - Abnormal? ....
- g. Cardiac arrest: ....

4. History of Cerebrovascular Disease:

For a & b code 1-Yes 2- No 3-Suspected CVA or TIA

- a. Diagnosis of Cerebrovascular Accident (CVA, Stroke) ....

➔ ***(If item 4a is "yes," skip to item 5.)***

- b. Any Transient Ischemic Attacks (TIA)? ....

5. History of Peripheral Vascular Disease (PVD, PVOD):

For a through e code 1 - Yes 2 - No 3 - Suspected

- a. Prior diagnosis of PVD: ....
- b. Amputation due to PVD: ....
- c. Limb amputation (other): ....
- d. Absent foot pulses: ....
- e. Claudication: ....

Date A6 : mm dd yy

Date A7: mm dd yy

Check box to left of item if unable to determine, and leave item (right) blank.

6. Hx of Heart Disease (other than CAD/CHD):

For all code: 1 - Yes 2 - No 3 - Suspected

- a. Congestive heart failure:
- b. Pericarditis :
- c. Pulmonary edema:

- **7. Prior diagnosis of diabetes:**
  1 - Yes 2 - No 3 - Suspected

➔ *If item 7 is "no," skip to item 8.*

- a. Insulin therapy:
  1 - Active 2 - Former 3 - Never
- b. Diabetes pills:
  1 - Active 2 - Former 3 - Never

- **8. History of Lung Disease:**
  Chronic obstructive pulmonary disease (COPD)
  1 - Yes 2 - No 3 - Suspected

- **9. Neoplasms (other than skin):**
  1 - Yes 2 - No 3 - Suspected

➔ *If item 9 is "no," skip to item 10.*

- a. Primary sites (up to 2)

10 - Lung	11 - Stomach/Esophagus
12 - Breast	13 - Pancreas
14 - Prostate	15 - Liver
16 - Colon/Rectal	17 - Myeloma
18 - Lymphoma/Leukemia	19 - Brain
20 - Ovary/Uterus	21 - Melanoma of skin
22 - Bladder	23 - Oral/Larynx
24 - Kidney	25 - Other, Unknown

- b. Year of first dx: 1 9

- **10. HIV Status:**
  1 - Positive 2 - Negative 3 - Unknown 4 - Can't disclose
- **11. AIDS Diagnosis:**
  1 - Positive 2 - Negative 3 - Unknown 4 - Can't disclose

C: Information at Study Start Date (Date A7)

You may use information from the period between 30 days prior to date at A7 to 30 days after date at A7

1. Height (at any time): **(REQUIRED)**

ft. in. **OR** cm.

If bilateral amputee give original height and check this box

- **2. Dry weight as ordered nearest study start date:**

wt: lbs. **OR** . kgs.

- **3. Undernourished or cachectic (malnourished) at study start date (A7)**
  1 - Yes 2 - No 3 - Suspected

4. Blood pressure and weight (most recent 3 readings before date (A7); please right justify entry):

- a. Predialysis BP (sitting preferred) for HD (any readings for PD patients):

		weight (rounded)
SBP /	DBP	
SBP /	DBP	
SBP /	DBP	

Required:
weight in pounds (lbs) **or in kg.** **rounded (check one)**

- b. Postdialysis BP (sitting preferred) for HD (skip for PD patients):
  1-Yes 2-No

		weight (rounded)
SBP /	DBP	
SBP /	DBP	
SBP /	DBP	

HEMODIALYSIS (if used on date A7)

➔ *If patient is using peritoneal dialysis, skip to PD section*

5. Hemodialysis prescription at date A7:

- a. Dialysate:
  1 - Bicarbonate 2 - Acetate
- b. Prescribed hours per treatment: hr. : min.
- c. Prescribed # of dialysis sessions per week:
- d. Blood flow rate (BFR): ml/min

If BFR varies please enter the prescribed or the most common "high" rate.

- e. Patient usually reusing dialyzer:
  1 - Yes 2 - No
- f. If reuse does not occur, please indicate reason:
  1 - Unit does not reuse 2 - Patient refuses
  3 - Hepatitis 4 - Other Medical
- g. Dialyzer type (see codes on back of page 5):

Only if you have entered code 9999, please specify below the manufacturer and dialyzer model:

manufacturer ____________

dialyzer model ____________

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Confidential Report
USRDS DMMS - Prospective

Date A6: [ ][ ] [ ][ ] [ ][ ]

Date A7: [ ][ ] [ ][ ] [ ][ ]
mm dd yy

Check box to left of item if unable to determine, and leave item (right) blank.

at date A6 | at date A7

- h. Vascular access in use: .... [ ] .... [ ]
  1 - AV Fistula
  2 - PTFE graft e.g. Gortex, Impra, Teflon
  3 - Bovine graft
  4 - Permanent catheter e.g. Permcath (any site)
  5 - Temporary internal jugular (IJ) catheter
  6 - Temporary subclavian catheter
  7 - Temporary femoral catheter
  8 - Other

at date A6 | at date A7

- i. Side of THIS access: .... [ ] .... [ ]
  1 - Right 2 - Left

j. First permanent vascular access created or attempted on or before date A7:
- Type (use codes 1-4 from item 5h above):................... [ ]
- Date of surgery: [ ][ ] [ ][ ] [ ][ ]
  mm dd yy
- Date of first use of THIS access before A7:
  (leave blank if never used before date A7)
  [ ][ ] [ ][ ] [ ][ ]
  mm dd yy
- Did this access require revision [ ] or did it fail ?... [ ]
  (Be sure to answer both boxes)
  1 - No, not before date A7
  2 - Yes, before date A6
  3 - Yes, between date A6 and date A7
- Did this access fail to mature before date A7?............. [ ]
  1 - Yes 2 - No
- k. Temporary access in central vein anytime before date A7... [ ]
  1 -Yes 2 -No

➔ *If item 5k is "no," skip to item 5l.*

- Any Subclavian (SC)........................... [ ]
- Any Internal jugular (IJ)...................... [ ]

1 - Right 2 - Left 3 - Right and Left 4 - Neither

- l. Number of HD treatments skipped by patient during 30 days prior to A7.................................. [ ]
  (do not include time in the hospital)
- m. Number of prescribed HD treatments shortened by more than 10 minutes by the patient during the 30 days prior to A7 (do not include skipped treatments):........................ [ ][ ]
- n. Did this patient have any peritoneal dialysis before date A7 (study start date)?... [ ]
  1 -Yes 2 -No

➔ *If item 5n is "no," skip to item 8 (Psychosocial Evaluation)*

- o. Date of placement for PD catheter:
  [ ][ ] [ ][ ] [ ][ ]
  mm dd yy

If patient is on hemodialysis on date A7, skip to page 4, Psychosocial Evaluation, item C8

PERITONEAL DIALYSIS (if used on date A7)

➔ ***If patient did not receive PD, then skip to Psychosocial Evaluation.***

6. Peritoneal dialysis prescription at study start date (Date A7):
- a. Dialysis location:... [ ]
  1 - Home 2 - Home Training 3 - In-center
- b. Type:... [ ]

1 - CAPD only 2 - Cycler(full when off cycler) 3 - Cycler (empty when off cycler) 4.- Combined

- c. Peritoneal Dialysis Prescription:

	Cycler	Manual
# of exchanges/ day	[ ][ ]	[ ]
liters/exchange (most common)	[ ].[ ]	[ ].[ ]
total hours/day on cycler	[ ][ ]	N/A
days/week	[ ]	[ ]
Total dialysate volume per 24 hrs	[ ][ ].[ ]	

- d. Type of PD catheter in use at date A7: .... [ ]
  1 - single cuff 2 - double cuff 3 - no cuff
- e. Date of placement for THIS catheter:
  [ ][ ] [ ][ ] [ ][ ]
  mm dd yy
- f. Was this the first peritoneal catheter for this patient?.. [ ]
  1 - Yes 2 - No
- g. Was this patient treated with hemodialysis before date A7 (study start date)?........................... [ ]
  1 - Yes 2 - No
- h Did this patient have a permanent vascular access before date A7 (study start date)?............................ [ ]
  1 - Yes 2 - No

➔ *If item 6h is "yes," go back to item 5j (go left) and complete 5j.*

7. Please give, on a voluntary basis, 24 hour dialysate urea N and creatinine in period of A6 to A7 + 30 days.

Total volume (drained) ....[ ][ ].[ ]

Dialysate Urea N - .mg/dl ....[ ][ ][ ].[ ]

Dialysate Creatinine .- mg/dl ....[ ][ ].[ ]

BUN (same day) .- mg/dl.................. ....[ ][ ][ ].[ ]

Serum creatinine .- mg/dl................ ....[ ][ ].[ ]

Date A6: [ ][ ] [ ][ ] [ ][ ]

Date A7: [ ][ ] [ ][ ] [ ][ ]
mm dd yy

Check box to left of item if unable to determine, and leave item (right) blank.

PSYCHOSOCIAL EVALUATION
Complete this section for both PD and Hemo patients

➔***Complete the following with information from the psycho-social evaluation most recent before the STUDY START DATE (or up to 30 days after A7). Use social worker's evaluation supplemented by the nurse's, and/or dietitian's records. You may want to consult with the social worker, dietitian, or ask the patient.***

- **8. Activities of daily living (currently or recently):** 1 - Yes 2 - No
  - a. Able to eat independently :..
  - b. Able to transfer independently:..................................
  - c. Able to ambulate independently (includes ambulating with an assistance device)........................
- **9. Marital status:**..
  1 - Single 2 - Married
  3 - Widowed 4 - Divorced 5 - Separated
- **10. Living alone:**..
  1 - Yes 2 - No
  3 - Nursing home, institution 4 - Homeless
- **11. Education:**..
  1 - Less than 12 Yrs. 2 - High School Grad
  3 - Some College 4 - College Grad
- **12. Primary occupation before ESRD:**.............................
  1 - Clerical
  2 - Professional
  3 - Tradeperson
  4 - Manual Labor
  5 - Student
  6 - Other
  7 - Not Employed Outside of Home
  8 - Homemaker
  9 - Disabled

- **13. Employment Level:**
- a Please indicate the one most appropriate employment category for the patient during the periods of time indicated.
  Please enter one number only in each box from the list below.

	24 mo. prior to ESRD - 6 mo. prior to <u>ESRD</u>	near date at A7
1 - Employed full time or full time student......	[ ]	[ ]

2 - Employed part time or part time student
3 - Homemaker
4 - Retired
5 - Never Employed
6- Unemployed
7 - Disabled
8 - Other (specify)

- b. If unemployed, is patient looking for employment:.....
  1 - Yes 2 - No

D: Laboratory Data

Complete with information closest to study start date (A7) from a period of up to3 months before study start date (A7) and one month after study start date (A7+ 30 days).

- **1. Cardiomegaly by X-ray:**..
  1 - Yes 2 - No
- **2. Left ventricular hypertrophy:**
  1 - Yes 2 - No
  - a. by EKG ....
  - b. by echocardiography..
- **3. Total serum calcium, predialysis:**............ [ ][ ] • [ ] mg/dl
- **4. Serum phosphate or phosphorus, predialysis:** .... [ ][ ] • [ ] mg/dl
- **5. Serum bicarbonate or CO_2, predialysis:**.............................. [ ][ ] • [ ] mEq/l

6. Hematocrit information (from the lab report)

- a. Hematocrit (If transfused, give value before blood transfusion):..... [ ][ ] • [ ] %
- b. Hemoglobin (If transfused, give value before transfusion................ [ ][ ] • [ ] g/dl
- c. Transfused in first 60 days of dialysis?............
  1 - Yes 2 - No

If item 6c is "no," skip to item 7.

- d. If transfused, number of transfusions in first 30 days of dialysis:..............................

7. Was the patient taking EPO (Erythropoietin)? ....
1 - Yes 2 - No

- a. During first 60 days of dialysis (between A6 and A7):..........................

If yes: iv.=1, subcutaneous = 2 ....

- b. During last month <u>before</u> ESRD:...................... (30 days prior to A6)

8. Serum Creatinine:

- a. Before first regular dialysis.. .... [ ][ ] • [ ] mg/dl
  (on day of first regular dialysis or on the closest day prior to date A6)
- b. Nearest day 60 (A7):..................... [ ][ ] • [ ] mg/dl

9. BUN or urea values: **Check here if urea:**............

- a. Before first regular dialysis: .... [ ][ ][ ] mg/dl
  (on day of 1st regular dialysis or on the closest day prior to date A6)

Patient Name__________________________________

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Date A6: [ ][ ] [ ][ ] [ ][ ]

Date A7: [ ][ ] [ ][ ] [ ][ ]
mm dd yy

Check box to left of item if unable to determine, and leave item (right) blank.

- b. Nearest day 60 (measurements must be from same date):
  Predialysis:.......................... [ ][ ][ ] mg/dl required
  Postdialysis:......................... [ ][ ][ ] mg/dl required
- c. Weights pre and post dialysis (must be on same day as 9b):
  weight in lb. [ ] or kg. [ ] rounded (check one)
  - predialysis:.............................. [ ][ ][ ] required
  - postdialysis:............................ [ ][ ][ ] required

➔ ***Dates for pre and post BUN values and pre and post weights MUST match.***

- **10. Predialysis or random Serum Albumin:** [ ] • [ ] g/dl

Complete with information closest to study start date (A7) from a period of up to 3 months before study start date (A7) to 1 month after study start date (A7+30)

11. Lipids:
- a. Cholesterol Total:...................... [ ][ ][ ] mg/dl
- b. HDL cholesterol:....................... [ ][ ][ ] mg/dl
- c. LDL cholesterol:....................... [ ][ ][ ] mg/dl
- d. Triglycerides:.................... [ ][ ][ ][ ] mg/dl

- **12. Serum intact PTH:**...................... [ ][ ][ ][ ] pg/ml
- **13. Serum Aluminum:** .... [ ][ ][ ][ ] µg/l

(Random or if DFO, please use base line measurement)

14. Residual Renal Function:
This section is important but is not an official requirement.

Please give all available information and/or obtain the measurements within period of date A6 to date A7 + 30 days, (i.e.days 0 -90 days ESRD) on a voluntary basis if at all possible:

- a. Urine collection time:

start............ [ ][ ] [ ][ ] | [ ][ ] : [ ][ ] [ ]
mm dd (Date) hr min (Time) AM=1 PM=2

end............. [ ][ ] [ ][ ] | [ ][ ] : [ ][ ] [ ]
mm dd (Date) hr min (Time) AM=1 PM=2

Total hours of urine collection (Verification).......... [ ][ ]

- b. Lab Values

	Value	Units
Urine Volume	[ ] , [ ][ ][ ]	ml or cc
Urine Creatinine	[ ] , [ ][ ][ ]	indicate units • mg/vol • mg/24 hrs. • mg/dl=mg%
Urine Urea Nitrogen	[ ] , [ ][ ][ ]	
Pre Creatinine*	[ ][ ] . [ ]	mg/dl
Pre BUN*	[ ][ ][ ]	mg/dl
Post Creatinine*	[ ][ ] . [ ]	mg/dl
Post BUN*	[ ][ ][ ]	mg/dl

* For the pre and post blood creatinine and BUN, please provide values taken ideally at the beginning (pre) and end (post) of URINE collection If this is not possible:
For hemo patients, enter values from measurements taken pre and post dialysis on a date as close as possible to the dates of urine collection.
For PD patients, enter blood creatinine and BUN values taken on a date as close as possible to the date of urine collection available.

15. Medications at time of A7, please copy the list of all medications as generic or trade name. (The dosage is not required)

1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

16. Was patient receiving at time of A7 injectable vitamin D (Calcijex) .... [ ]
1 - yes 2 - no