PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2004

[Before completing please read instructions at the bottom of this page and on pages 5 and 6]

PATIENT IDENTIFICATION

MAKE CORRECTIONS TO PATIENT INFORMATION ON LABEL IN THE SPACE BELOW

Place Patient Data Label Here

12. **If this patient is unknown or was not dialyzed in the facility at any time during OCT 2003-MAR 2004 return the blank form to the Network.**

13. Patient's Ethnicity (Check appropriate box). ❑ non-Hispanic ❑ Hispanic, Mexican American (Chicano) ❑ Hispanic, Puerto Rican ❑ Hispanic, Cuban American ❑ Hispanic, Other _____ ❑ Unknown

14a. **Patient's height (MUST COMPLETE):** _____inches **OR** _____centimeters

14b. **Patient's weight (abdomen empty) (first clinic visit weight after Oct. 1, 2003):** _____ . ___lbs. OR _____ . ___ kg.

15. **Did patient have limb amputation(s) prior to Mar. 31, 2004:** ❑ Yes ❑ No ❑ Unknown

16. Has the patient ever been diagnosed with any type of diabetes? ❑ Yes (go to 17) ❑ No (go to 18) ❑ Unknown (go to 18)

17. If question 16 was answered **YES**, was the patient taking medications to control the diabetes during the study period? ❑ Yes ❑ No ❑ Unknown If **YES**, was the patient using insulin during the study period? ❑ Yes ❑ No ❑ Unknown

Individual Completing Form **(Please print):**

First name: _____ Last name: _____ Title: _____

Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____

INSTRUCTIONS FOR COMPLETING THE PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2004

The label on the top left side of this form contains the following patient identifying information (#'s 1-11). If the information is incorrect make corrections to the right of the label.

1. LAST and first name.
2. DATE of birth (DOB) as MM/DD/YYYY.
3. SOCIAL Security Number (SSN).
4. HEALTH Insurance Claim Number (HIC), (**same as Medicare number**).
5. GENDER (1=Male; 2=Female).
6. RACE (1=American Indian/Alaska Native; 2=Asian; 3=Black; 4=White; 5=Unknown; 6=Pacific Islander; 7=Mid East Arabian; 8=Indian Subcontinent; 9=Other Multiracial).
7. PRIMARY cause of renal failure by CMS-2728 code.
8. DATE, as MM/DD/YYYY, that the patient began a regular course of dialysis.
9. ESRD Network number. Do not make corrections to this item.
10. Facility's Medicare provider number.
11. The most RECENT date this patient returned to peritoneal dialysis following: transplant failure, an episode of regained kidney function, or switched modality.
12. If the patient is unknown or if the patient was not dialyzed in the facility at any time during OCT 2003 through MAR 2004, send the blank form back to the ESRD Network office. Provide the name and address of the facility providing services to this patient on December 31, 2003, if known.
13. Patient's Ethnicity. Please verify the patient's ethnicity with the patient and check appropriate box.

14a. Enter the patient's height in inches or centimeters. HEIGHT MUST BE ENTERED, do not leave this field blank. You may ask the patient his/her height to obtain this information. If the patient had both legs amputated, record pre-amputation height and check YES for item 15.

14b. Enter the patient's weight (abdomen empty) in pounds or kilograms. Use the FIRST CLINIC VISIT weight on or after October 1, 2003.

15. For the purpose of this study, check NO if this patient has had toe(s), finger(s), or mid-foot (Symes) amputation; but **check YES if this patient has had a below-knee, below-elbow, or more proximal (extensive) amputation prior to Mar. 31, 2004.**
16. Check either "Yes", "No", or "Unknown" to indicate if the patient has ever been diagnosed with any type of diabetes. If **YES**, proceed to question 17.
17. Check either "Yes", "No", or "Unknown" to indicate if the patient was taking medications to control the diabetes during the study period. If the answer to 17 is **YES**, please check either "Yes", "No", or "Unknown" to indicate if the patient was using insulin during the study period. Study period is OCT 2003 -MAR 2004.

PLEASE COMPLETE ITEMS 18 THROUGH 24 ON PAGE 2, 3, AND 4 OF THIS DATA COLLECTION FORM.
INSTRUCTIONS FOR COMPLETING THESE ITEMS ARE ON PAGES 5 AND 6.

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2004 (CONTINUED)

18. ANEMIA MANAGEMENT: For each lab question below, enter the first lab value obtained for each two-month time period: OCT-NOV 2003, DEC 2003-JAN 2004, FEB-MAR 2004. Enter NF/NP if the lab value cannot be located.

	OCT-NOV 2003	DEC 2003-JAN 2004	FEB-MAR 2004
A. First laboratory hemoglobin (Hgb) during the two-month time period:	____ ____ . ____ g/dL (If NF/NP go to 18C)	____ ____ . ____ g/dL (If NF/NP go to 18C)	____ ____ . ____ g/dL (If NF/NP go to 18C)
B.1.a. Did the patient receive Epoetin at anytime during the 30 days before the Hgb in 18A was drawn?	Epoetin: ❑ Yes ❑ No ❑ Unknown	Epoetin: ❑ Yes ❑ No ❑ Unknown	Epoetin: ❑ Yes ❑ No ❑ Unknown
B.1.b. Did the patient receive Darbepoetin (Aranesp™) at anytime during the 30 days before the Hgb in 18A was drawn?	Darbepoetin: ❑ Yes ❑ No ❑ Unknown	Darbepoetin: ❑ Yes ❑ No ❑ Unknown	Darbepoetin: ❑ Yes ❑ No ❑ Unknown
B.2.a. What was the PRESCRIBED Epoetin dose in units/month at the time immediately BEFORE the Hgb in 18A was drawn? (See instructions on page 5)	Epoetin: _____ units/month	Epoetin: _____units/month	Epoetin: _____ units/month
B.2.b. What was the PRESCRIBED Darbepoetin dose in micrograms for the MONTH immediately BEFORE the Hgb in 18A was drawn? (See instructions on page 5)	Darbepoetin: _____ mcg/month	Darbepoetin: _____ mcg/month	Darbepoetin: _____ mcg/month
B.3.a. How many times per month was Epoetin prescribed?	Epoetin: _____ x per month	Epoetin: _____ x per month	Epoetin: _____ x per month
B.3.b. How many times per month was Darbepoetin prescribed?	Darbepoetin: _____ x per month	Darbepoetin: _____ x per month	Darbepoetin: _____ x per month
B.4.a. What was the prescribed route of administration for Epoetin? (Check all that apply)	Epoetin: ❑ IV ❑ SC ❑ Unknown	Epoetin: ❑ IV ❑ SC ❑ Unknown	Epoetin: ❑ IV ❑ SC ❑ Unknown
B.4.b. What was the prescribed route of administration for Darbepoetin? (Check all that apply)	Darbepoetin: ❑ IV ❑ SC ❑ Unknown	Darbepoetin: ❑ IV ❑ SC ❑ Unknown	Darbepoetin: ❑ IV ❑ SC ❑ Unknown
C. First serum ferritin concentration during the two-month time period:	___ ___ ___ ___ ng/mL	___ ___ ___ ___ ng/mL	___ ___ ___ ___ ng/mL
D. First % transferrin (iron) saturation during the two-month time period:	_____ _____ _____ %	_____ _____ _____ %	_____ _____ _____ %
E. Was iron prescribed at any time during the two-month time period?	❑ Yes ❑ No (go to 19) ❑ Unknown (go to 19)	❑ Yes ❑ No (go to 19) ❑ Unknown (go to 19)	❑ Yes ❑ No (go to 19) ❑ Unknown (go to 19)
F. If yes, what was the prescribed route of iron administration? (Check all that apply).	❑ IV ❑ PO ❑ Unknown	❑ IV ❑ PO ❑ Unknown	❑ IV ❑ PO ❑ Unknown
G. If the patient was prescribed IV iron, what was the total dose of IV iron **administered** during the two-month time period?	_____ mg	_____ mg	_____ mg

19. SERUM ALBUMIN: Enter the first serum albumin obtained for each two-month time period: OCT-NOV 2003, DEC 2003-JAN 2004, FEB-MAR 2004. Enter NF/NP if the lab value cannot be located. Check the method used (BCG/bromcresol green or BCP/bromcresol purple) by the lab to determine serum albumin. If lab method unknown, call lab to find out.

	OCT-NOV 2003	DEC 2003-JAN 2004	FEB-MAR 2004
A. First serum albumin during the two-month time period:	_____ . _____ g/dL	_____ . _____ g/dL	_____ . _____ g/dL
B. Check lab method used: BCG = bromcresol green; BCP = bromcresol purple	❑ BCG ❑ BCP	❑ BCG ❑ BCP	❑ BCG ❑ BCP

20. PERITONEAL DIALYSIS ADEQUACY: The remainder of this form lists a series of questions regarding adequacy measurements for this patient. Please answer questions 20A and B FOR EACH TWO-MONTH TIME PERIOD indicated. Then continue to pages 3 and 4.

	OCT-NOV 2003	DEC 2003-JAN 2004	FEB-MAR 2004
A. Was the patient on peritoneal dialysis at any time during this period?	❑ Yes ❑ No ❑ Unknown	❑ Yes ❑ No ❑ Unknown	❑ Yes ❑ No ❑ Unknown
B. Was the patient on hemodialysis or did patient receive a transplant at any time during this period?	❑ Yes ❑ No ❑ Unknown	❑ Yes ❑ No ❑ Unknown	❑ Yes ❑ No ❑ Unknown

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2004 (CONTINUED)

21. ADEQUACY: The following data are requested for the FIRST ADEQUACY determination during the months OCTOBER 2003 through MARCH 2004. Starting with the first adequacy measurement in these months, enter the adequacy measurements/results listed below that were obtained. (Please DO NOT record more than one adequacy measurement done for any one month.) Please read instructions on Pages 5 and 6 before completing this section. Enter NF/NP if information cannot be located.

21. Was adequacy measurement done during OCT 2003-MAR 2004?	❑ Yes ❑ No ❑ Unknown
21A. Date of **FIRST** adequacy measurement between 10-1-2003 to 3-31-2004	___ / ___ / _____ (mm) (dd) (yyyy)
21B. Patient's dialysis modality when adequacy measures were performed	❑ CAPD ❑ Cycler (See definitions in instructions on p. 5)
21C. Patient's weight at the time of this adequacy assessment (abdomen empty) (Circle lbs or kgs)	_____ . ___ lbs /kgs
21D. Weekly Kt/V_{urea} (dialysate and urine clearance)	____ . _____ _____
21E. Method by which V above was calculated: Check one. (If unknown please call lab.)	❑ %BW ❑ Hume ❑ Watson ❑ Other _____
21F. Weekly Creatinine Clearance (dialysate and urine clearance)	__ __ __ . __ L/wk
21G. Is this Creatinine Clearance corrected for body surface area, using standard methods? (See instructions on page 6)	❑ Yes ❑ No ❑ Unknown
21H. 24 hr DIALYSATE **volume** (prescribed and ultrafiltration)	___ ___ ___ ___ ___mL
21I. 24 hr DIALYSATE **urea nitrogen**:	___ ___ ___ . ___ mg/dL
21J. 24 hr DIALYSATE **creatinine:**	___ ___ . ___ mg/dL
21K. 24 hr URINE **volume**: (If 24 hr urine was not located check NF/NP.)	___ ___ ___ ___ mL ❑ NF/NP
21L. 24 hr URINE **urea nitrogen**:	___ ___ ___ . ___ mg/dL
21M. 24 hr URINE **creatinine:**	___ ___ ___ . ___ mg/dL
21N. SERUM BUN at the time this adequacy assessment was done	___ ___ ___ mg/dL
21O. SERUM creatinine at the time this adequacy assessment was done	___ ___ . ___ mg/dL
21P.1. Most recent 4 hour dialysate/plasma creatinine ratio (D/P Cr) from a peritoneal equilibration test (PET).	____ . _____ _____
2. Date of most recent D/P Cr	____ / ____ / _____ (mm) (dd) (yyyy)

22. PERITONEAL DIALYSIS PRESCRIPTION: For the following questions – record the PD prescription in effect at the time the adequacy measures/results recorded in Question 21 were performed. Please read instructions on Page 6 before completing this section. Enter NF/NP if information cannot be located.

	Prescription at the time adequacy was measured in 21A
22A. **CAPD PRESCRIPTION** (this includes patients with one overnight exchange using an assist device)	
1. Number of dialysis days per week	_____ (# days)
2. Total dialysate volume infused per 24 hours	___ ___ ___ ___ ___ mL/24 hrs
3. Total number of exchanges per 24 hours (including overnight exchange)	_____ (# exchanges)
22B. **CYCLER PRESCRIPTION**	
1. Number of dialysis days per week	_____ (# days)
2. Total dialysate volume infused per 24 hours	___ ___ ___ ___ ___ mL/24 hrs
3. Total dialysis time	
a. Total nighttime dialysis time	_____hrs _____min
b. Total daytime dialysis time	_____hrs _____min
c. Total amount of time the patient is dry during 24 hours	_____hrs _____min
(**Note:** 3a+b+c = 24 hours)	
4. Nighttime Prescription (excluding last bag fill)	
a. Volume of a single nighttime exchange	___ ___ ___ ___ mL/exchange
b. Number of dialysis exchanges during the nighttime	_____ (#/nighttime)
5. Daytime Prescription (including last bag fill)	
a. Volume of a single daytime exchange	___ ___ ___ ___ mL/exchange
b. Number of dialysis exchanges during the daytime	_____ (#/daytime)
6. Does the cycler prescription described above include TIDAL dialysis?	❑ Yes ❑ No ❑ Unknown
22C. Based on the adequacy result from questions 21A-O,	
1. Was the collection repeated?	❑ Yes ❑ No ❑ Unknown
2. Was the prescription changed?	❑ Yes ❑ No ❑ Unknown

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FOR 2004: (CONTINUED)

23. ADEQUACY: The following data are requested for the SECOND ADEQUACY determination during the months NOVEMBER 2003 through MARCH 2004. Starting with the second adequacy measurement in these months, enter the adequacy measurements/ results listed below that were obtained. (Please DO NOT record more than one adequacy measurement done for any one month.) Please read instructions on Page 6 before completing this section. Enter NF/NP if information cannot be located.

23. Was second adequacy measurement done during NOV 2003-MAR 2004?	❑ Yes ❑ No ❑ Unknown
23A. Date of **SECOND** adequacy measurement between 11-1-2003 to 3-31-2004	___ / ___ / _____ (mm) (dd) (yyyy)
23B. Patient's dialysis modality when adequacy measures were performed	❑ CAPD ❑ Cycler (See definitions in instructions on p. 5)
23C. Patient's weight at the time of this adequacy assessment (abdomen empty) (Circle lbs or kgs)	_____.____ lbs /kgs
23D. Weekly Kt/V_{urea} (dialysate and urine clearance)	____ . _____ _____
23E. Method by which V above was calculated: Check one. (If unknown please call lab)	❑ %BW ❑ Hume ❑ Watson ❑ Other _____
23F. Weekly Creatinine Clearance (dialysate and urine clearance)	__ __ __ . __ L/wk
23G. Is this Creatinine Clearance corrected for body surface area, using standard methods? (See instructions on page 6)	❑ Yes ❑ No ❑ Unknown
23H. 24 hr DIALYSATE **volume** (prescribed and ultrafiltration)	___ ___ ___ ___ ___mL
23I. 24 hr DIALYSATE **urea nitrogen**:	___ ___ ___ . ___ mg/dL
23J. 24 hr DIALYSATE **creatinine:**	___ ___ . ___ mg/dL
23K. 24 hr URINE **volume**: (If 24 hr urine was not located check NF/NP.)	___ ___ ___ ___ mL ❑ NF/NP
23L. 24 hr URINE **urea nitrogen**:	___ ___ ___ . ___ mg/dL
23M. 24 hr URINE **creatinine:**	___ ___ ___ . ___ mg/dL
23N. SERUM BUN at the time this adequacy assessment was done	___ ___ ___ mg/dL
23O. SERUM creatinine at the time this adequacy assessment was done	___ ___ . ___ mg/dL
23P.1.If the patient has had a 4-Hour D/P Cr performed from a PET since the time of the first adequacy test, enter the value and the date the test was performed. If not performed, enter NP.	____ . _____ _____ ____ / ____ / _____ (mm) (dd) (yyyy)

24. PERITONEAL DIALYSIS PRESCRIPTION: For the following questions – record the PD prescription in effect at the time the adequacy measures/results recorded in Question 23 were performed. Please read instructions on Page 6 before completing this section. Enter NF/NP if information cannot be located.

	Prescription at the time adequacy was measured in 23A
24A. **CAPD PRESCRIPTION** (this includes patients with one overnight exchange using an assist device)	
1. Number of dialysis days per week	_____ (# days)
2. Total dialysate volume infused per 24 hours	___ ___ ___ ___ ___ mL/24 hrs
3. Total number of exchanges per 24 hours (including overnight exchange)	_____ (# exchanges)
24B. **CYCLER PRESCRIPTION**	
1. Number of dialysis days per week	_____ (# days)
2. Total dialysate volume infused per 24 hours	___ ___ ___ ___ ___ mL/24 hrs
3. Total dialysis time	
a. Total nighttime dialysis time	_____hrs _____min
b. Total daytime dialysis time	_____hrs _____min
c. Total amount of time the patient is dry during 24 hours	_____hrs _____min
(**Note:** 3a+b+c = 24 hours)	
4. Nighttime Prescription (excluding last bag fill)	
a. Volume of a single nighttime exchange	___ ___ ___ ___ mL/exchange
b. Number of dialysis exchanges during the nighttime	_____ (#/nighttime)
5. Daytime Prescription (including last bag fill)	
a. Volume of a single daytime exchange	___ ___ ___ ___ mL/exchange
b. Number of dialysis exchanges during the daytime	_____ (#/daytime)
6. Does the prescription described above include TIDAL dialysis?	❑ Yes ❑ No ❑ Unknown
24C. Based on the adequacy result from questions 23A-O,	
1. Was the collection repeated?	❑ Yes ❑ No ❑ Unknown
2. Was the prescription changed?	❑ Yes ❑ No ❑ Unknown

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2004 (CONTINUED)

INSTRUCTIONS FOR COMPLETING QUESTIONS 18 THROUGH 20 (continued from page 1): To answer questions 18 through 20 review the patient's clinic or facility medical record FOR EACH TWO-MONTH TIME PERIOD: OCT 1, 2003 through NOV 30, 2003, DEC 1, 2003 through JAN 31, 2004, and FEB 1, 2004 through MAR 31, 2004. Do not leave any items blank. Enter NF/NP if the following information cannot be located.

18A: Enter the patient's FIRST hemoglobin (Hgb) value determined by the laboratory for EACH two-month time period. If not found or not performed during the two-month time period, enter NF/NP.

18B.1: Check the appropriate box to indicate if the patient received EPOETIN or DARBEPOETIN (Aranesp™) at anytime during the 30 days BEFORE the date of the hemoglobin value in 18A. If the answer is NO to both, skip to question 18C.

18B.2: If **Epoetin** was prescribed, enter the **PRESCRIBED MONTHLY** Epoetin dose, **not the administered dose**, in units given at the time immediately before the hemoglobin value in 18A, even if the patient did not receive the dose. This includes any prescribed dose not given because of an error or the patient missed a dose, etc. Enter "0" if the patient was on "Hold". (For the purposes of this collection, a "Hold" order will be considered a 0 unit prescribed dose.)

If **Darbepoetin** (Aranesp™) was prescribed, enter the **PRESCRIBED MONTHLY** Darbepoetin dose, **not the administered dose**, in micrograms per month during the month immediately before the date of the hemoglobin value in 18A, even if the patient did not receive the dose. This includes any prescribed dose not given because of an error or the patient missed a dose, etc. Enter "0" if the patient was on "Hold". (For the purposes of this collection, a "Hold" order will be considered a 0 mcg/month prescribed dose.)

18B.3: Enter the number of times per month that Epoetin was prescribed **OR** the number of times per month Darbepoetin was prescribed.

18B4: Check the appropriate box to indicate the prescribed route of administration for Epoetin or for Darbepoetin (intravenous [IV] or subcutaneous [SC]). If the patient received Epoetin or Darbepoetin IV and SC during the month, please check both boxes.

18C: Enter the patient's FIRST serum ferritin concentration recorded EACH two-month time period. If a serum ferritin concentration test was not found or not performed every two-month time period, enter the value for the time period when performed and record NF/NP for the other time period(s).

18D: Enter the patient's FIRST % transferrin (iron) saturation recorded EACH two-month time period. If a % transferrin (iron) saturation test was not found or not performed every two-month time period, enter the value for the time period when performed and record NF/NP for the other time period(s).

18E: Check either "Yes", "No", or "Unknown" to indicate if iron was prescribed at any time during the two-month time periods.

18F: If the answer to 18E is "Yes", please check the appropriate space to indicate the route of iron administration (intravenous [IV] or by mouth [PO]) for each two-month time period. Check every route of administration that was prescribed each time period.

18G: If the patient was prescribed IV iron, add together all doses that were given during each two-month time period OCT-NOV 2003, DEC 2003-JAN 2004, FEB-MAR 2004 and enter the TOTAL dose of IV iron (in mg) **administered**.

19A: Enter the patient's FIRST serum albumin value recorded EACH two-month time period.

19B: Check the method used by the laboratory to determine the serum albumin levels (bromcresol green or bromcresol purple). If you do not know what method the laboratory used, call the laboratory to find out this information.

20A: Check the appropriate response (yes or no) for each two-month time period, indicating whether this patient was on peritoneal dialysis at any time during each of the specified two-month time periods.

20B: Check the appropriate response (yes or no) for each two-month time period, indicating whether this patient was on hemodialysis or received a transplant at any time during each of the specified two-month time periods.

INSTRUCTIONS FOR COMPLETING QUESTIONS 21 THROUGH 24: To answer questions 21 through 24 review the patient's clinic or facility medical record and provide the requested data for each of the first two adequacy measurements and PD prescriptions in effect at the time the adequacy measurements were done during the months OCTOBER 2003 through MARCH 2004. DO NOT record more than one adequacy measurement done for any one month.

21. Check "yes", "no", or "unknown" to indicate if an adequacy measurement was done between OCT 1, 2003 through MAR 31, 2004.

21A: Enter the first date on which adequacy of dialysis was assessed for the first measure obtained between OCT 1, 2003 through MAR 31, 2004. DO NOT record more than one adequacy measurement done for any one month.

21B: Check the modality of peritoneal dialysis this patient was on at the time the corresponding adequacy of dialysis measure was obtained. CHECK either CAPD or Cycler. CAPD includes patients with one overnight exchange using an assist device. Cycler includes patients using an automated device for exchanges.

21C: Enter the patient's weight (with abdomen empty) at the clinic/facility visit when the adequacy measurements were obtained, circle lbs or kgs as appropriate.

21D: Enter the TOTAL WEEKLY Kt/V_{urea} for the first adequacy measurement indicated on 21A between OCT 1, 2003 through MAR 31, 2004. NOTE: Whether or not you have a value for weekly Kt/V_{urea} for this adequacy assessment, please complete the corresponding values for questions 21H-21I for 24-hour dialysate volume, 24-hour dialysate urea and question 21K for 24-hour urine volume. If the patient is not anuric, complete the corresponding value for question 21L, the 24-hour urine urea, if this value is available. Enter NF/NP for all values when not found or not performed. If your unit calculates a daily Kt/V_{urea}, multiply this result by 7.0 and enter the result in the appropriate space(s). If this patient did not dialyze each day of the week, then multiply the daily Kt/V_{urea} by the number of days the patient did dialyze.

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2004 (CONTINUED)

21E: Check the method used to calculate the V in the Kt/V_{urea} measurement; % BW = percent of body weight; Hume and Watson are two nomograms used to calculate V based on several of these parameters - weight, height, age, gender. If method used to calculate V is not known, please call lab to ascertain method. Please do not leave blank.

21F: Enter the TOTAL WEEKLY CREATININE CLEARANCE for the first adequacy measurement indicated on 21A between OCT 1, 2003 through MAR 31, 2004. NOTE: Whether or not you have a value for weekly creatinine clearance for this adequacy assessment, please complete the corresponding values for questions 21H and 21J for 24-hour dialysate volume, 24-hour dialysate creatinine and question 21K for 24-hour urine volume. If the patient is not anuric, complete the corresponding value for question 21M, the 24-hour urine creatinine, if this value is available. Enter NF/NP for all values when not found or not performed. If your unit calculates a daily creatinine clearance multiply this result by 7.0 and enter the result in the appropriate space(s). If this patient did not dialyze each day of the week, then multiply the daily creatinine clearance by the number of days the patient did dialyze.

21G: Check Yes or No if the weekly creatinine clearance was normalized for body surface area (i.e., the result is multiplied by $1.73m^2$ and divided by the patient's body surface area [BSA]). Standard methods for establishing BSA are: the DuBois and DuBois method; the Gehan and George method; and the Haycock method. If you do not have this information, call the laboratory that provided the creatinine clearance value for this information. Please do not leave blank.

21H, I, and J: Enter the measured 24-hour DIALYSATE volume (includes prescribed and ultrafiltration volumes), urea nitrogen and creatinine obtained for the first adequacy measurement obtained between OCT 1, 2003 through MAR 31, 2004. If a 24-hour dialysate volume, urea nitrogen or creatinine were NOT measured in this time period, enter NF/NP (for not found or not performed) in the appropriate spaces. ONLY ENTER ACTUAL MEASURED 24-HOUR DIALYSATE VOLUME. DO NOT ENTER AN EXTRAPOLATED DIALYSATE VOLUME. Please report the 24-hour dialysate volume as a combination of the prescribed fill volume and the ultrafiltration volume.

21K, L, and M: Enter the 24-hour URINE volume, urea nitrogen and creatinine obtained for the first adequacy assessment obtained between OCT 1, 2003 through MAR 31, 2004. ONLY ENTER ACTUAL MEASURED 24-HOUR URINE VOLUME—DO NOT ENTER AN EXTRAPOLATED URINE VOLUME. If 24-hour urine volume was not collected check NF/NP for not found or not performed. If NF/NP is checked, SKIP TO QUESTION 21N. If urine urea nitrogen and creatinine were not found or not measured in this time period, enter NF/NP in the appropriate spaces.

21N, O: Enter the SERUM BUN and SERUM CREATININE obtained for the first adequacy assessment obtained between OCT 1, 2003 through MAR 31, 2004. Enter NF/NP in the appropriate spaces for all time periods when not found or not performed.

21P: **(**1) Enter the most recent four hour dialysate/plasma creatinine ratio (D/P Cr) from a peritoneal equilibration test (PET).
(2) Enter the date of the most recent D/P Cr. The test result and corresponding date of the most recent D/P Cr may be outside the 6-month study period. If never found or performed record NF/NP. Date cannot be after 3/31/04 or prior to the first day of peritoneal dialysis.

22: To respond to questions 22A through 22C record the peritoneal dialysis (PD) prescription in effect at the time of the first adequacy measures/results recorded in question 21 performed between OCT 1, 2003 through MAR 31, 2004. Complete all items that are applicable.

22A: CAPD PRESCRIPTION. Use the CAPD prescription category for all CAPD patients including patients with one overnight exchange using an assist device. **(1)** Enter the number of days per week for which this patient underwent peritoneal dialysis. **(2)** Enter the total dialysate volume in mL infused over a 24-hour period and **(3)** the number of exchanges per 24-hour period **PRESCRIBED** for CAPD at the time the first adequacy measurements were performed.

22B: CYCLER PRESCRIPTION. **(1)** Enter the number of days per week for which this patient underwent peritoneal dialysis. **(2)** Enter the total dialysate volume in mL infused over a 24-hour period. **(3)** Total dialysis time - (Note: 2a+b+c = 24 hours): **(3a)** Enter the total nighttime dialysis time, **(3b)** the total daytime dialysis dwell time, and **(3c)** the total amount of time the patient is dry during 24 hours. If the patient is never dry in 24 hours enter a value of 0 hours. The hours entered in 2a, b, & c should equal 24 hours. **(4)** Nighttime Prescription (excluding last bag fill): **(4a)** Enter the volume of a single nighttime exchange and **(4b)** the number of dialysis exchanges during the nighttime **PRESCRIBED** for CYCLER NIGHTTIME at the time the first adequacy measurements were performed. Include in the CYCLER NIGHTTIME prescription only those exchanges provided by an automated device. DO NOT include in this category any last bag fill or option that the patient carries after unhooking from the cycler or any daytime dwells as these exchanges are recorded in the DAYTIME PRESCRIPTION information. If different inflow volumes are used, report average inflow volume. **(5)** Daytime Prescription (including last bag fill): **(5a)** Enter the volume of a single daytime exchange and **(5b)** the number of dialysis exchanges during the daytime **PRESCRIBED** for CYCLER DAYTIME at the time the first adequacy measurements were performed. Include in the CYCLER DAYTIME prescription only those exchanges performed after the patient disconnects from the cycler and/or a last bag fill or option that the patient carries during the day. ANY OTHER EXCHANGES PERFORMED USING THE CYCLER SHOULD BE INCLUDED UNDER CYCLER NIGHTTIME PRESCRIPTION. If different inflow volumes are used, report average inflow volume.

(6) Check the appropriate box, "yes" or "no", indicating whether this patient's peritoneal dialysis prescription included TIDAL dialysis. TIDAL patients are cycler patients for whom the dialysate is partially drained between some exchanges.

22C: **(1)** Check the appropriate box, "yes" or "no", indicating whether the adequacy collection was repeated, and **(2)** check the appropriate box "yes" or "no", indicating whether the prescription changed following the first adequacy measurement performed between OCT 1, 2003 through MAR 31, 2004.

23: Check "yes", "no", or "unknown" to indicate if an adequacy measurement was done between NOV 1, 2003 through MAR 31, 2004.

23A-O: See instructions for 21A-21O and complete for second adequacy measurement performed between NOV 1, 2003 through MAR 31, 2004. DO NOT record more than one adequacy measurement done for any one month.

23P: Record the value and date of the patient's PET if a new one was performed since the time of the first adequacy test. If not performed enter NP.

24A-C: See instructions for 22A-22C and complete for the peritoneal dialysis (PD) prescription in effect at the time of the second adequacy measures/results recorded in question 23 performed between NOV 1, 2003 through MAR 31, 2004.