

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2003

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

<p>PATIENT IDENTIFICATION</p> <div style="border: 1px solid gray; background-color: #e0e0e0; height: 80px; margin: 10px 0; text-align: center; padding: 10px;"> Place Patient Data Label Here </div>	<p style="text-align: center;">MAKE CORRECTIONS TO PATIENT INFORMATION ON LABEL IN THE SPACE BELOW</p>
12. If the above patient information is incorrect make corrections in space above then continue to question 13. Please verify patient's race and answer question 13 below. If patient unknown or was not dialyzed in the unit at any time during OCT 2002 – MAR 2003 return the blank form to the Network.	
13. Patient's Ethnicity (Check appropriate box). <input type="checkbox"/> non-Hispanic <input type="checkbox"/> Hispanic, Mexican American (Chicano) <input type="checkbox"/> Hispanic, Puerto Rican <input type="checkbox"/> Hispanic, Cuban American <input type="checkbox"/> Hispanic, Other <input type="checkbox"/> Unknown	
14a. Patient's height (MUST COMPLETE): _____ inches OR _____ centimeters	
14b. Patient's weight (abdomen empty) (first clinic visit weight after Oct. 1, 2002): _____ lbs. OR _____ kg.	
15. Did patient have limb amputation(s) prior to Mar. 31, 2003: <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Has the patient ever been diagnosed with any type of diabetes? <input type="checkbox"/> Yes (go to 17) <input type="checkbox"/> No (go to 18) <input type="checkbox"/> Unknown (go to 18)	
17. If question 16 was answered YES , was the patient taking medications to control the diabetes during the study period? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , was the patient using insulin during the study period? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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 2003

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.
3. SOCIAL Security Number (SSN).
5. SEX (1=Male; 2=Female; 9=Unknown).
7. PRIMARY cause of renal failure by CMS-2728 code.
9. ESRD Network number.
Do not make corrections to this item. | 2. DATE of birth (DOB) as MM/DD/YYYY.
4. HEALTH Insurance Claim Number (HIC), (same as Medicare number).
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).
8. DATE, as MM/DD/YYYY, that the patient began a regular course of dialysis.
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. Review the patient and facility-specific information contained on the pre-printed label. Please verify the patient's race, item 6 above. If any of the information is incorrect write corrections in the space to the right of the label. If the patient is unknown or if the patient was not dialyzed in the unit at any time during OCT 2002 through MAR 2003, 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, 2002, 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, 2002.
 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, 2003.**
 16. Check either "Yes", or "No", or "Unknown" to indicate if the patient has ever been diagnosed with any type of diabetes. If **YES**, proceed to question 17.
 17. If the answer to question 16 is **YES**, please check either "Yes" or "No" 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" or "No" to indicate if the patient was using insulin during the study period. Study period is OCT 2002 -MAR 2003.

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 2003 (CONTINUED)

18. ANEMIA MANAGEMENT: For each lab question below, enter the first lab value obtained for each two-month time period: OCT-NOV 2002, DEC 2002-JAN 2003, FEB-MAR 2003. Enter NF/NP if the lab value cannot be located.

	OCT-NOV 2002	DEC 2002-JAN 2003	FEB-MAR 2003
A. First laboratory hemoglobin (Hgb) during the two-month time period:	_____ . _____ g/dL	_____ . _____ g/dL	_____ . _____ g/dL
B.1. Was there a prescription for Epoetin or Darbepoetin (Aranesp™) immediately before the Hgb in 18A was drawn?	Epoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) Darbepoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C)	Epoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) Darbepoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C)	Epoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) Darbepoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C)
B.2. What was the PRESCRIBED Epoetin dose in units/wk at the time immediately BEFORE the Hgb in 18A was drawn or the PRESCRIBED Darbepoetin dose in micrograms for the MONTH immediately BEFORE the Hgb in 18A was drawn? (See instructions on page 5)	Epoetin: _____ units/wk Darbepoetin: _____ mcg/month	Epoetin: _____ units/wk Darbepoetin: _____ mcg/month	Epoetin: _____ units/wk Darbepoetin: _____ mcg/month
B.3. How many times per week was Epoetin prescribed or how many times per month was Darbepoetin prescribed?	Epoetin: _____ x per week Darbepoetin: _____ x per month	Epoetin: _____ x per week Darbepoetin: _____ x per month	Epoetin: _____ x per week Darbepoetin: _____ x per month
B.4. What was the prescribed route of administration? (Check all that apply)	Epoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC Darbepoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC	Epoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC Darbepoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC	Epoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC Darbepoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No (go to 19)	<input type="checkbox"/> Yes <input type="checkbox"/> No (go to 19)	<input type="checkbox"/> Yes <input type="checkbox"/> No (go to 19)
F. If yes, what was the prescribed route of iron administration? (Check all that apply).	<input type="checkbox"/> IV <input type="checkbox"/> PO	<input type="checkbox"/> IV <input type="checkbox"/> PO	<input type="checkbox"/> IV <input type="checkbox"/> PO
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 2002, DEC 2002-JAN 2003, FEB-MAR 2003. Enter NF/NP if the lab value cannot be located. Check the method used (BCG/bromocresol green or BCP/bromocresol purple) by the lab to determine serum albumin. If lab method unknown, call lab to find out.

	OCT-NOV 2002	DEC 2002-JAN 2003	FEB-MAR 2003
A. First serum albumin during the two-month time period:	_____ . _____ g/dL	_____ . _____ g/dL	_____ . _____ g/dL
B. Check lab method used: BCG = bromocresol green; BCP = bromocresol purple	<input type="checkbox"/> BCG <input type="checkbox"/> BCP	<input type="checkbox"/> BCG <input type="checkbox"/> BCP	<input type="checkbox"/> BCG <input type="checkbox"/> 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 2002	DEC 2002-JAN 2003	FEB-MAR 2003
A. Was the patient on peritoneal dialysis at any time during this period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Was the patient on hemodialysis or did patient receive a transplant at any time during this period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2003 (CONTINUED)

21. ADEQUACY: The following data are requested for the first ADEQUACY determination during the months OCTOBER 2002 through MARCH 2003. 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.

	<input type="checkbox"/> Check box if adequacy measurement was not done during OCT 2002-MAR 2003
21A. Date of first adequacy measurement between 10-1-2002 to 3-31-2003	___ / ___ / ___ (mm) (dd) (yy)
21B. Patient's dialysis modality when adequacy measures were performed	<input type="checkbox"/> CAPD <input type="checkbox"/> Cycler
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. (See instructions on page 6)	<input type="checkbox"/> %BW <input type="checkbox"/> Hume <input type="checkbox"/> Watson <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 collected check NP. If patient's urine production was negligible, i.e., < 200 cc of urine/24 hr, then check anuric and go to question 21N)	_____ mL <input type="checkbox"/> NP <input type="checkbox"/> anuric
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) (yy)

22. PERITONEAL DIALYSIS PRESCRIPTION: For the following questions – record the PD prescription in effect immediately prior to the time the adequacy measures/results recorded in Question 21 were performed. Please read instructions on Page 6 before completing this section.

	Prescription prior to date in 21A
22A. Number of dialysis days per week	_____ (# days)
22B. CAPD PRESCRIPTION (this includes patients with one overnight exchange using an assist device) 1. Total dialysate volume infused per 24 hours 2. Total number of exchanges per 24 hours (including overnight exchange)	_____ mL/24 hrs _____ (# exchanges)
22C. CYCLER PRESCRIPTION 1. Total dialysate volume infused per 24 hours 2. Total dialysis time a. Total nighttime dialysis time b. Total daytime dialysis time c. Total amount of time the patient is dry during 24 hours (Note: 2a+b+c = 24 hours) 3. Nighttime Prescription (excluding last bag fill) a. Volume of a single nighttime exchange b. Number of dialysis exchanges during the nighttime 4. Daytime Prescription (including last bag fill) a. Volume of a single daytime exchange b. Number of dialysis exchanges during the daytime	_____ mL/24 hrs ____ hrs ____ min ____ hrs ____ min ____ hrs ____ min _____ mL/24 hrs ____ hrs ____ min ____ hrs ____ min _____ mL/exchange _____ (#/nighttime) _____ mL/exchange _____ (#/daytime)
22D. Does the prescription described above include TIDAL dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22E. Based on the adequacy result from questions 21A-O, 1. Was the collection repeated? 2. Was the prescription changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FOR 2003: (CONTINUED)			
<p>23. ADEQUACY: The following data are requested for the second ADEQUACY determination during the months NOVEMBER 2002 through MARCH 2003. 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.</p>		<p>24. PERITONEAL DIALYSIS PRESCRIPTION: For the following questions – record the PD prescription in effect immediately prior to the time the adequacy measures/results recorded in Question 23 were performed. Please read instructions on Page 6 before completing this section.</p>	
	<input type="checkbox"/> Check box if second adequacy measurement was not done during NOV 2002-MAR 2003		Prescription prior to date in 23A
23A. Date of second adequacy measurement between 11-1-2002 to 3-31-2003	___ / ___ / ___ (mm) (dd) (yy)	24A. Number of dialysis days per week	_____ (# days)
23B. Patient's dialysis modality when adequacy measures were performed	<input type="checkbox"/> CAPD <input type="checkbox"/> Cycler	24B. CAPD PRESCRIPTION (this includes patients with one overnight exchange using an assist device)	
23C. Patient's weight at the time of this adequacy assessment (abdomen empty) (Circle lbs or kgs)	_____ lbs /kgs	1. Total dialysate volume infused per 24 hours	_____ mL/24 hrs
23D. Weekly Kt/V _{urea} (dialysate and urine clearance)	____ . ____	2. Total number of exchanges per 24 hours (including overnight exchange)	_____ (# exchanges)
23E. Method by which V above was calculated: Check one. (See instructions on page 6)	<input type="checkbox"/> %BW <input type="checkbox"/> Hume <input type="checkbox"/> Watson <input type="checkbox"/> Other	24C. CYCLER PRESCRIPTION	
23F. Weekly Creatinine Clearance (dialysate and urine clearance)	____ . ____ L/wk	1. Total dialysate volume infused per 24 hours	_____ mL/24 hrs
23G. Is this Creatinine Clearance corrected for body surface area, using standard methods? (See instructions on page 6)	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Total dialysis time	_____ hrs _____ min
23H. 24 hr DIALYSATE volume (prescribed and ultrafiltration)	_____ mL	a. Total nighttime dialysis time	_____ hrs _____ min
23I. 24 hr DIALYSATE urea nitrogen:	_____ . ____ mg/dL	b. Total daytime dialysis time	_____ hrs _____ min
23J. 24 hr DIALYSATE creatinine:	_____ . ____ mg/dL	c. Total amount of time the patient is dry during 24 hours	_____ hrs _____ min
23K. 24 hr URINE volume: (If 24 hr urine was not collected check NP. If patient's urine production was negligible, i.e., < 200 cc of urine/24 hr, then check anuric and go to question 23N)	_____ mL <input type="checkbox"/> NP <input type="checkbox"/> anuric	(Note: 2a+b+c = 24 hours)	
23L. 24 hr URINE urea nitrogen:	_____ . ____ mg/dL	3. Nighttime Prescription (excluding last bag fill)	
23M. 24 hr URINE creatinine:	_____ . ____ mg/dL	a. Volume of a single nighttime exchange	_____ mL/exchange
23N. SERUM BUN at the time this adequacy assessment was done	_____ mg/dL	b. Number of dialysis exchanges during the nighttime	_____ (#/nighttime)
23O. SERUM creatinine at the time this adequacy assessment was done	_____ . ____ mg/dL	4. Daytime Prescription (including last bag fill)	
23P.1. Most recent 4 hour dialysate/plasma creatinine ratio (D/P Cr) from a peritoneal equilibration test (PET)	____ . ____	a. Volume of a single daytime exchange	_____ mL/exchange
2. Date of most recent D/P Cr	___ / ___ / ___ (mm) (dd) (yy)	b. Number of dialysis exchanges during the daytime	_____ (#/daytime)
		24D. Does the prescription described above include TIDAL dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		24E. Based on the adequacy result from questions 23A-O,	
		1. Was the collection repeated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		2. Was the prescription changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2003 (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, 2002 through NOV 30, 2002, DEC 1, 2002 through JAN 31, 2003, and FEB 1, 2003 through MAR 31, 2003. 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 there was a prescription for EPOETIN or for DARBEPOETIN (Aranesp™) IMMEDIATELY BEFORE the date of the hemoglobin value in 18A. If the answer is NO, skip to question 18C.

18B.2: If **Epoetin** was prescribed, enter the **PRESCRIBED WEEKLY** 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 prescribed less frequently than weekly, divide the prescribed Epoetin dose by the number of weeks in the dosing interval to obtain weekly Epoetin dose. If the Epoetin dose is prescribed by the number of days, divide the dose by the number of days and multiply by 7 to obtain weekly Epoetin dose (example-EPO 5000 units every 10 days. 5000 units divided by 10 days and multiplied by 7 days equals 3500 units per week). If using a sliding scale for Epoetin dosing, total all the doses given during the week and enter the value.

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 week that Epoetin was prescribed or the number of times per month Darbepoetin was prescribed. If Epoetin was prescribed less than once per week, enter NA.

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" or "No" 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 2002, DEC 2002-JAN 2003, FEB-MAR 2003 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 immediately prior to the adequacy measurements during the months OCTOBER 2002 through MARCH 2003. DO NOT record more than one adequacy measurement done for any one month.

21A: Enter the first date on which adequacy of dialysis was assessed for the first measure obtained between OCT 1, 2002 through MAR 31, 2003. DO NOT record more than one adequacy measurement done for any one month. Check the labeled box above date area if an adequacy measurement was not done during the time frame.

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.

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, 2002 through MAR 31, 2003. 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 2003 (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, 2002 through MAR 31, 2003. 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 urea 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, 2002 through MAR 31, 2003. 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, 2002 through MAR 31, 2003. 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, OR if the patient's urine production was negligible, i.e., < 200 cc of urine/24 hours, then check anuric. If NP or anuric 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, 2002 through MAR 31, 2003. 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.
22:	To respond to questions 22A through 22E record the peritoneal dialysis (PD) prescription in effect immediately prior to the first adequacy measures/results recorded in question 21 performed between OCT 1, 2002 through MAR 31, 2003. Complete all items that are applicable.
22A:	Enter the number of days per week for which this patient underwent peritoneal dialysis.
22B:	CAPD PRESCRIPTION. Use the CAPD prescription category for all CAPD patients including patients with one overnight exchange using an assist device. (1) Enter the total dialysate volume in mL infused over a 24-hour period and (2) the <u>number of exchanges per 24-hour period</u> PRESCRIBED for CAPD at the time the first adequacy measurements were performed.
22C:	CYCLER PRESCRIPTION. (1) Enter the total dialysate volume in mL infused over a 24-hour period. (2) Total dialysis time - (Note: 2a+b+c = 24 hours): (2a) Enter the total nighttime dialysis time, (2b) the total daytime dialysis dwell time, and (2c) the <u>total amount of time the patient is dry during 24 hours</u> . 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. (3) Nighttime Prescription (excluding last bag fill): (3a) Enter <u>the volume of a single nighttime exchange</u> and (3b) <u>the number of dialysis exchanges during the nighttime</u> 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 cyclor or any daytime dwells as these exchanges are recorded in the DAYTIME PRESCRIPTION information. If different inflow volumes are used, report average inflow volume. (4) Daytime Prescription (including last bag fill): (4a) Enter <u>the volume of a single daytime exchange</u> and (4b) <u>the number of dialysis exchanges during the daytime</u> 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 cyclor 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.
22D:	Check the appropriate box, yes or no, whether this patient's peritoneal dialysis prescription included TIDAL dialysis. TIDAL patients are cyclor patients for whom the dialysate is partially drained between some exchanges.
22E:	(1) Check the appropriate box, yes or no, indicating whether the adequacy collection was repeated, or the prescription changed, following the first adequacy measurement performed between OCT 1, 2002 through MAR 31, 2003.
23A-P:	See instructions for 21A-21P and complete for second adequacy measurement performed between NOV 1, 2002 through MAR 31, 2003. DO NOT record more than one adequacy measurement done for any one month. Check the labeled box above date area if an adequacy measurement was not done during the time frame.
24A-E:	See instructions for 22A-22E and complete for the peritoneal dialysis (PD) prescription in effect immediately prior to the second adequacy measures/results recorded in question 23 performed between NOV 1, 2002 through MAR 31, 2003.