CONFIDENTIAL REPORT
USRDS DATA VALIDATION STUDY

Check box in margin if unable to determine, and leave item blank.

TRANSPLANT INFORMATION

PLACE LABEL HERE

Network: ☐☐ Abstractor: ☐☐

Date completed: ..... ☐☐ mm ☐☐ dd ☐☐ yy

☐ 1. Date of Birth: ..... ☐☐ mm ☐☐ dd 1☐☐☐ yyyy

2. Ethnicity: ..... ☐
- 1 - Hispanic Origin
- 2 - Not of Hispanic Origin
- 8 - Unable to determine

3. Race: ..... ☐
- 1 - American Indian/Alaskan Native
- 2 - Asian/Pacific Islander
- 3 - Black
- 4 - White
- 5 - Other
- 8 - Unable to determine

☐ 4. Sex: ..... ☐
- 1 - Male
- 2 - Female

☐ 5. Patient's SSN: ☐☐☐ ☐☐ ☐☐☐☐

☐ 6. Medicare Claim Number: ☐☐☐☐☐☐☐☐ BIC: ☐☐

TRANSPLANT RECIPIENT INFORMATION

☐ 7. Date of this Transplant: .. ☐☐ mm ☐☐ dd ☐☐ yy

☐ 8. This Transplant Number: ..... ☐

9. Recipient Blood Type: ..... ☐
- 1 - O
- 2 - A
- 3 - B
- 4 - AB
- 8 - Unable to determine

10. PRA (percent reactive antibody):

☐ A. Highest: ..... ☐☐.☐

☐ B. At time of transplant: ..... ☐☐.☐

11. Recipient HLA Typed? ..... ☐
- 1 - Yes
- 2 - No
- 8 - Unable to determine

If yes, enter the results (if unknown leave blank):

Locus A ..... ☐☐ ☐☐

Locus B ..... ☐☐ ☐☐

Locus DR ..... ☐☐ ☐☐

12. Creatinine Decline without dialysis at one week post-transplant? ..... ☐
- 1 - Yes
- 2 - No
- 8 - Unable to determine

☐ 13. Outcome of this transplant: ..... ☐
- 1 - Failed
- 2 - Died with functioning transplant
- 3 - Alive with functioning transplant

If failed, enter date of failure: ☐☐ mm ☐☐ dd ☐☐ yy

a. Primary cause: ☐☐☐ b. Secondary Cause: ☐☐☐

TRANSPLANT DONOR INFORMATION

14. Donor Type: ..... ☐
- 1 - Cadaveric, (leave item B blank)
- 2 - Living related, (leave item A blank)
- 3 - Living unrelated, (leave item A blank)
- 8 - Unable to determine

A. If cadaveric, enter type: ..... ☐
- 1 - Local
- 2 - Shared
- 8 - Unable to determine

B. If living related, or unrelated enter type: ☐
- 1 - HLA Identical
- 2 - Haplo Identical
- 3 - Haplo Dissimilar
- 4 - Identical Twin
- 8 - Unable to determine

15. Donor Ethnicity: ..... ☐
- 1 - Hispanic Origin
- 2 - Not of Hispanic Origin
- 8 - Unable to determine

16. Donor Race: ..... ☐
- 1 - American Indian/Alaskan Native
- 2 - Asian/Pacific Islander
- 3 - Black
- 4 - White
- 5 - Other
- 8 - Unable to determine

17. Donor Sex: ..... ☐
- 1 - Male
- 2 - Female
- 8 - Unable to determine

18. Donor Age: ..... ☐☐ ☐

19. Donor Blood Type: ..... ☐
- 1 - O
- 2 - A
- 3 - B
- 4 - AB
- 8 - Unable to determine

20. Donor HLA Typed? ..... ☐
- 1 - Yes
- 2 - No
- 8 - Unable to determine

If yes, enter the results (if unknown leave blank):

Locus A ..... ☐☐ ☐☐

Locus B ..... ☐☐ ☐☐

Locus DR ..... ☐☐ ☐☐

21. Viral Infections at time of harvest:
- 1 - Yes
- 2 - No
- 8 - Unable to determine

HBsAg Positive ..... ☐

CMV Antibody ..... ☐

Other ..... ☐

22. Cold Ischemia Time (hr:min): .. ☐☐:☐☐ ☐

23. Warm Ischemia Time (minutes): ..... ☐☐ ☐

24. Pulmonic Perfusion Time (hr:min): ☐☐:☐☐ ☐

CONFIDENTIAL REPORT
USRDS DATA VALIDATION STUDY

Check box in margin if unable to determine, and leave item blank.

DIALYSIS PATIENT INFORMATION

PLACE LABEL HERE

Network: ☐☐ Abstractor: ☐☐

Date completed: ..... ☐☐ ☐☐ ☐☐
mm dd yy

1. Was Medicare the primary insurer throughout the period of 10/01/87 to 03/31/88: ..... ☐
1 - Yes 2 - No 8 - Unable to determine

If no, enter the date that Medicare became the primary insurer and the name of the other primary insurer(s)

☐ Medicare: ..... ☐☐ ☐☐ ☐☐
mm dd yy

Other (specify): _____

☐ 2. Dialysis/transplant provider as of 10/01/87: ☐☐☐☐☐☐

☐ 3. Date of Birth:... ☐☐ ☐☐ 1☐☐☐
mm dd yyyy

4. Ethnicity: ..... ☐
1 - Hispanic Origin
2 - Not of Hispanic Origin
8 - Unable to determine

5. Race: ..... ☐
1 - American Indian/Alaskan Native
2 - Asian/Pacific Islander
3 - Black
4 - White
5 - Other
8 - Unable to determine

☐ 6. Sex: ..... ☐
1 - Male
2 - Female

☐ 7. Patient's SSN: ☐☐☐ ☐☐ ☐☐☐☐

☐ 8. Medicare Claim Number: ☐☐☐ ☐☐ ☐☐☐☐ BIC: ☐☐

9. Current Address:

☐ State: ☐☐

☐ Zip Code:... ☐☐☐☐☐

10. Date of first ESRD Service: ☐☐ ☐☐ ☐☐ ☐
mm dd yy

11. Type of first ESRD service: ..... ☐
1 - Dialysis without home or self-care training
2 - Dialysis with home or self-care training
3 - Transplant
8 - Unable to determine

12. Primary disease causing ESRD: ☐☐☐☐☐ ☐
Use ICD9CM codes; left justified

13. Secondary Causes (enter if known, else leave blank):

a. ☐☐☐☐☐ c. ☐☐☐☐☐ ☐

b. ☐☐☐☐☐ d. ☐☐☐☐☐

14. Status of patient as of 03/31/88: ..... ☐
1 - Living, on dialysis, [skip items 15 & 16]
2 - Living with functioning graft, [skip items 15 & 16]
3 - Living, recovered renal function, [skip items 15 & 16]
4 - Living, unknown status [skip items 15 & 16]
5 - Dead, [complete items 15 & 16]
8 - Unable to determine [skip items 15 & 16]

15. Date of death: ..... ☐☐ ☐☐ ☐☐ ☐
mm dd yy

16. Causes of death:

Primary ..... ☐☐ ☐

Secondary..... ☐☐ ☐☐ ☐☐ ☐

Cause of Death Codes:
01 - Pericarditis (including cardiac tamponade)
02 - Myocardial infarction, acute
03 - Cardiac (other than 01 or 02)
04 - Cerebrovascular (including spontaneous subdural hematoma)
05 - Embolism, air
06 - Embolism, pulmonary
07 - GI hemorrhage
08 - Vascular access hemorrhage
09 - Hemorrhage (other than 04, 07, or 08)
10 - Pulmonary infection
11 - Septicemia
12 - Viral hepatitis
13 - Infection (other than 10, 11, 12)
14 - Hyperkalemia
15 - Pancreatitis
16 - Malignancy
17 - Withdrawal from dialysis
18 - Suicide
19 - Accidental death, treatment related (other than 05)
20 - Accidental death not treatment related
21 - Unknown cause
22 - Other

Source of causes of death: ..... ☐ ☐
1 - Death Certificate (see instructions)
2 - Other:

Page ____ of ____

DIALYSIS TREATMENTS

Pat. ID

Complete one line for each dialysis treatment type that the patient utilized in the time period of October 1, 1987 to March 31, 1988. IF YOU NEED ADDITIONAL SPACE, CONTINUE ON ANOTHER COPY OF THIS FORM.

Item 5: Enter the number of sessions between the begin and end date by using actual counts from records for the dialysis types of hemodialysis and intermittent peritoneal. Leave blank for CCPD and CAPD.

Item 7: If the patient is transferred to another dialysis facility or for transplant, complete this item with the # of the facility/unit.

Refer to the instruction sheets for additional information on all items.

CODES:

DIALYSIS TYPE
1 - Hemodialysis
2 - Intermittent Peritoneal
3 - CAPD
4 - CCPD
8 - Unable to determine

DIALYSIS SETTING
1 - Full-care in unit
2 - Self-care in unit
3 - Self-care training
4 - Home care
8 - Unable to determine

REASONS FOR THE END DATE:

Use the following reasons for change from or to a known type or setting of dialysis:
- 01 - Change in dialysis type/setting due to patient preference.
- 02 - Change in dialysis setting due to travel.
- 03 - Change to CAPD due to vascular access problems (in hemodialysis)
- 04 - Change to hemodialysis due to peritonitis (recurrent fungal, resistant on PD).
- 05 - Change to hemodialysis due to peritoneal catheter problems.
- 06 - Change in dialysis setting due to the completion of training.
- 07 - Change in dialysis type and/or setting, reason undetermined.
- 08 - Change in prescribed no. of sessions per week.

Use the following reasons for a gap in dialysis treatments:
- 09 - Gap due to hospitalization.
- 10 - Gap due to travel.
- 11 - Gap due to transfer.
- 12 - Gap due to transplant.
- 13 - Gap due to recovery of renal function.
- 14 - Gap due to death.
- 15 - Gap, reason undetermined.

	(1)Dialysis Type	(2)Dialysis Setting	(3)Start Date mm dd yy	(4)End Date mm dd yy	(5)No. of Sessions	(6)Rx. no. per week	(7)Explanation of a end date b	(8)New Facility/Unit
1.			8	8				
2.			8	8				
3.			8	8				
4.			8	8				
5.			8	8				
6.			8	8				
7.			8	8				
8.			8	8				
9.			8	8				
10.			8	8				
11.			8	8				
12.			8	8				

Page ___ of ___

CONFIDENTIAL REPORT
USRDS DATA VALIDATION STUDY

Check box in margin if unable to determine, and leave item blank.

HOSPITAL STAY INFORMATION

PLACE LABEL HERE

Network: ☐☐ Abstractor: ☐☐

Date completed: ..... ☐☐ ☐☐ ☐☐
mm dd yy

☐ 1. Date of Birth: ..... ☐☐ ☐☐ 1☐☐☐
mm dd yyyy

2. Ethnicity: ..... ☐
1 - Hispanic Origin
2 - Not of Hispanic Origin
8 - Unable to determine

3. Race: ..... ☐
1 - American Indian/Alaskan Native
2 - Asian/Pacific Islander
3 - Black
4 - White
5 - Other
8 - Unable to determine

☐ 4. Sex: ..... ☐
1 - Male
2 - Female

☐ 5. Patient's SSN: ☐☐☐ ☐☐ ☐☐☐☐

☐ 6. Medicare Claim Number: ☐☐☐ ☐☐ ☐☐☐☐ BIC: ☐☐

HOSPITAL STAY 1

☐ A. Hospital: _____

Provider No.: ..... ☐☐☐☐☐☐

☐ B. Admission Date: ..... ☐☐ ☐☐ ☐☐
mm dd yy

☐ C. Discharge Date: ..... ☐☐ ☐☐ ☐☐
mm dd yy

☐ D. Diagnosis Codes:

a. ☐☐☐☐☐ d. ☐☐☐☐☐
b. ☐☐☐☐☐ e. ☐☐☐☐☐
c. ☐☐☐☐☐ f. ☐☐☐☐☐

HOSPITAL STAY 2

A. Hospital: _____ ☐

Provider No.: ..... ☐☐☐☐☐☐

B. Admission Date: ..... ☐☐ ☐☐ ☐☐ ☐
mm dd yy

C. Discharge Date: ..... ☐☐ ☐☐ ☐☐ ☐
mm dd yy

D. Diagnosis Codes: ☐

a. ☐☐☐☐☐ d. ☐☐☐☐☐
b. ☐☐☐☐☐ e. ☐☐☐☐☐
c. ☐☐☐☐☐ f. ☐☐☐☐☐

HOSPITAL STAY 3

A. Hospital: _____ ☐

Provider No.: ..... ☐☐☐☐☐☐

B. Admission Date: ..... ☐☐ ☐☐ ☐☐ ☐
mm dd yy

C. Discharge Date: ..... ☐☐ ☐☐ ☐☐ ☐
mm dd yy

D. Diagnosis Codes: ☐

a. ☐☐☐☐☐ d. ☐☐☐☐☐
b. ☐☐☐☐☐ e. ☐☐☐☐☐
c. ☐☐☐☐☐ f. ☐☐☐☐☐

HOSPITAL STAY 4

A. Hospital: _____ ☐

Provider No.: ..... ☐☐☐☐☐☐

B. Admission Date: ..... ☐☐ ☐☐ ☐☐ ☐
mm dd yy

C. Discharge Date: ..... ☐☐ ☐☐ ☐☐ ☐
mm dd yy

D. Diagnosis Codes: ☐

a. ☐☐☐☐☐ d. ☐☐☐☐☐
b. ☐☐☐☐☐ e. ☐☐☐☐☐
c. ☐☐☐☐☐ f. ☐☐☐☐☐