Baseline Visit 1

EARNEST

Patient Details

Participant Initials: ☐☐☐ **Subject ID:** ☐☐☐☐☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐ **Study Title:**

Visit Details

Visit V1 **Visit Date** ☐☐ / ☐☐ / ☐☐

Patient details

Participant Type (mark with 'X')

☐ **DONOR**

☐ **CONTROL**

Has the patient met the inclusion/exclusion criteria ☐ **Yes** ☐ **No**

Demographics

Age ☐☐ Years

Gender

☐ Female

☐ Male

Ethnicity

☐ Caucasian

☐ Afro-Caribbean

☐ Asian

☐ Other ☐☐☐☐☐☐☐☐☐☐

ANTHROPOMETRIC MEASUREMENTS

Height ☐.☐☐ (m)

Weight ☐☐☐.☐ (Kg)

Blood pressure history

High Blood Pressure ☐ **Yes** ☐ **No**

If YES, Year diagnosed ☐☐☐☐

Name of the person Filling the form ☐☐☐☐☐☐☐☐☐☐ Signature ☐☐☐☐☐☐☐☐☐☐

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CURRENT DRUG THERAPY

Are you taking any **PRESCRIBED** medications? ☐ **Yes (enter below)**

☐ **None**

Medication Name	Dose (if known)

COMPLETE THIS SECTION (For medications above) AFTER PATIENT VISIT USING A REFERENCE GUIDE (E.g. BNF)

Any medication for high blood pressure ? ☐ **Yes** ☐ No

If yes, (Please answer all applicable)

ACE Inhibitor	☐ **Yes**	☐ No
Angiotensin receptor blocker	☐ **Yes**	☐ No
Beta Blocker	☐ **Yes**	☐ No
Thiazide diuretic	☐ **Yes**	☐ No
Calcium channel blocker	☐ **Yes**	☐ No
Alpha-blocker	☐ **Yes**	☐ No

Are you taking hormone replacement ? ☐ **Yes** ☐ No

Are you taking an antidepressant ? ☐ **Yes** ☐ No

Are you taking regular NSAIDs ? (Regular = more than once a day for the last week) ☐ **Yes** ☐ No

LIFE STYLE ASSESSMENTS

Are you a smoker ? ☐ **Never Smoked** ☐ **Current Smoker** ☐ **Ex-Smoker**

If you are a smoker or ex-smoker, number of Cigarettes smoked per day ☐ / per day

Number of years smoked ? ☐

TOTAL PACK YEARS ☐ **[Pack years = (number per day ÷ 20) x number of years]**

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BLOOD PRESSURE AND HEART RATE MEASUREMENTS

SEATED

		Systolic	Diastolic
Seated blood pressure	**1.**	☐☐☐	☐☐☐
	2.	☐☐☐	☐☐☐
	3.	☐☐☐	☐☐☐
	Average of last 2 readings	☐☐☐	☐☐☐

Seated heart rate (From BP monitor)	**1.**	☐☐☐
	2.	☐☐☐
	3.	☐☐☐
	Average of last 2 readings	☐☐☐

SUPINE

		Systolic	Diastolic
Supine blood pressure	**1.**	☐☐☐	☐☐☐
	2.	☐☐☐	☐☐☐
	3.	☐☐☐	☐☐☐
	Average of last 2 readings	☐☐☐	☐☐☐

Supine heart rate (From BP monitor)	**1.**	☐☐☐
	2.	☐☐☐
	3.	☐☐☐
	Average of last 2 readings	☐☐☐

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HAEMODYNAMIC MEASUREMENTS

		Quality Index	
1.	☐☐☐		1. ☐☐☐
2.	☐☐☐		2. ☐☐☐
3.	☐☐☐		3. ☐☐☐
Average	☐☐☐		Average ☐☐☐

Take the average of the first 2 readings if they are within 5% of each other, if not take a third reading and average the closest 2 readings. Please note that

	Systolic	Di
1.	☐☐☐	☐☐☐
2.	☐☐☐	☐☐☐
3.	☐☐☐	☐☐☐
Average	☐☐☐	☐☐☐

Average the same 2 readings as used above

Central (Integrated) Mean blood pressure

1.	☐☐☐
2.	☐☐☐
3.	☐☐☐
Average	☐☐☐

Average the same 2 readings as used above

PWV

Is a calliper sing used? ☐ **Yes** ☐ **No** **Use the same measuring device at next visit**

Notch ☐☐☐

Notch to ☐☐☐

Carotid- femoral Pulse

		SD
1.	☐☐.☐	± ☐.☐
2.	☐☐.☐	± ☐.☐
3.	☐☐.☐	± ☐.☐
Average	☐☐.☐	± ☐.☐

Take the average of the first 2 readings if they are within 0.5 m/s of each other, if not take a third reading and average the closest 2 readings

Name of the person Filling the form ☐

Signature ☐

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24 h ABPM Results

ABPM MAKE/Model : Please use the same ABPM monitor at the next visit ☐

FILL BELOW and ATTACH A PRINTOUT OF THE SUMMARY SHEET

		Systolic	Diastolic
No. of valid day-time measure-ments recorded	☐	**Mean daytime Blood pressure**	☐☐☐ ☐☐☐
		Mean daytime heart rate	☐☐☐ **BPM**
		Standard deviation daytime Blood pressure	☐☐☐.☐ ☐☐☐.☐
No. of valid night time measure-ments recorded	☐	**Mean night time Blood pressure**	☐☐☐ ☐☐☐
		Mean night time heart rate	☐☐☐ **BPM**
		STD night time Blood pressure	☐☐☐.☐ ☐☐☐.☐
		Mean 24h Blood pressure	☐☐☐ ☐☐☐
		Mean 24h heart rate	☐☐☐ **BPM**
		STD 24h Blood pressure	☐☐☐.☐ ☐☐☐.☐

Isotopic GFR

[ONLY APPLICABLE FOR DONOR PATIENTS]

Absolute iGFR (mL/min) ☐

Normalised iGFR for BSA ☐

Split iGFR (%)

Left	Right

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BLOOD RESULTS

Haematology Test	Result	Units
WBC		Enter Units
Hb		Enter Units
Platelets		Enter Units

Sodium	☐☐☐	mmol/L	
Potassium	☐.☐	mmol/L	
Urea	☐☐.☐☐	mmol/L	
Creatinine	☐☐☐	umol/L	
eGFR	☐☐☐	ml/min	**eGFR: Ensure that the patient has had a meat free diet on the day of this test**
Albumin	☐☐.☐	g/L	
Calcium (corrected)	☐.☐☐	mmol/L	
Phosphate	☐.☐☐	mmol/L	

CRP			**If no value given then enter the value of the cut-off e.g. 0.003 g/L**
	Fill in the value with decimals	**Units**	

Nephrectomy details [DONORS ONLY - COMPLETE AFTER SCHEDULED OPERATION]

Did the patient undergo a nephrectomy?

If YES, date of nephrectomy : (dd/mm/yy) ☐☐ / ☐☐ / ☐☐

If No, was the patient considered as a control : ☐ **Yes** **(use the same subject id)**

☐ **No**

Name of the person Filling the form

Signature