SUSTAIN BASELINE DATA COLLECTION FORM
Revised 2/4/2014
(both pediatric and adult data elements)

Patient Demographics

Did the patient begin Home PN over 90 days ago? ☐ Yes ☐ No

Date began Home PN ☐ ☐ ☐ (Please select) ☐

Patient Number (As designated by study) (will be assigned once the record is saved)

Attending Physician's Name

Discharging Institution Name

PN Home Infusion Care Provider Name

Patient Birth Date ☐ ☐ ☐ (Please select) ☐

1. Gestational age at birth (☐ weeks gestation)
2. All age children: Birthweight: ☐ grams

Gender ☐ Male ☐ Female

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic nor Latino

Race (select all that apply) ☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White

Mobility status: ☐ Ambulatory ☐ Bedrest

Who does patient live with? ☐ Alone

Someone else (check all that apply) ☐ Parent
☐ Spouse
☐ Significant Other
☐ Child
Baseline Nutrition Status

Current Height/Length: ___ cm
Usual Weight/weight prior to illness: ___ Kg
When did the patient weigh this amount? (Please select) ___ ___ ___ (Please select) ___
Current Weight: ___ Kg

Pediatric Elements

Weight for Height/Length: ___ % (percentile)
BMI: ___ % (percentile)
Head Circumference (for children under 3 years of age): ___ cm

Current Labs

(complete as many as you have)
Date Labs Collected: (Please select) ___ ___ ___ (date closest to most labs drawn)
Serum Albumin: ___ g/dL
Platelet Count: ___ /uL (per microliter)
Total Bilirubin: ___ mg/dL
Direct Bilirubin: ___ mg/dL
AST: ___ U/L
ALT: ___ U/L
BUN: ___ mg/dL
Creatinine: ___ mg/dL

Insurance Coverage (check all that apply)
- Private Insurance
- Medicare
- Medicaid
- Personal Payment
- Medicare Supplement
- Unknown
- Other: Please specify:

Hired professional assistance

Don't know

Other: Please specify:

Insurance Coverage (check all that apply)
Select Primary Indication for Home PN

(Please be as specific as possible)

☐ Bowel Rest
☐ Enteritis/Colitis
☐ Chemotherapy
☐ Infectious
☐ C. diff
☐ Diverticulitis, non-obstructing
☐ Giardia
☐ Viral
☐ Other: Please specify:

☐ Inflammatory
☐ Crohns
☐ Graft vs. Host
☐ Ischemia bowel/Intestinal angina
☐ Necrotizing Enterocolitis (NEC)
☐ Non-specific enteritis/colitis
☐ Radiation
☐ Ulcerative Colitis
☐ Eosinophilic esophagitis
☐ Other: Please specify:

☐ Idiopathic
☐ Pancreatitis
☐ Acute
☐ Chronic

☐ Dysmotility
☐ Hirschsprung’s pediatric
☐ Hirschsprung’s adult
☐ Ileus, prolonged
☐ Autonomic (i.e. 2o to Diabetes)
☐ Idiopathic
☐ Post-op
☐ Scleroderma
☐ Intestinal pseudoobstruction
Failure to Thrive/Malnutrition

- Pediatric
  - Feeding intolerance
  - Socio-economic
  - Neglect/Munchausen
  - Other: Please specify:

- Adult
  - Cancer Cachexia
  - Cardiac Cachexia
  - Hepatic failure
  - Pulmonary Cachexia
  - Renal Cachexia
  - General Malnutrition
  - Pre-op nutrition support

GI Fistula

- Benign
- Malignant

Malabsorption

- Celiac disease
- Congenital Malabsorption
- Cystic fibrosis
- Idiopathic
- Pancreatic insufficiency
- Scleroderma
- Other: Please specify:

Obstruction

- Malignant
  - GYN
  - GI
  - Other: Please specify:

- Benign
  - Adhesive
  - Stricture
  - Crohn’s disease
Radiation
Diverticulitis
Other: Please specify:

☐ Short Bowel Syndrome - Non fistulous in origin
- Bowel resection
- Crohn’s disease
- Radiation
- Other: Please specify:

☐ Small bowel stoma: Yes ☐ No
     - Where is stoma?
         - Jejunum
         - Ileum
         - Duodenum
         - Don’t know

☐ Colonic stoma: Yes ☐ No

☐ Large bowel in continuity with small bowel: Yes ☐ No

☐ Ileo-cecal valve present: Yes ☐ No

Length of remaining small bowel in continuity: cm (current or last known measurement)
Measurement date: 2003

Length of remaining large bowel in continuity: Less than 50% ☐ Greater than 50% ☐

Bowel measurement technique (before any lengthening procedure):
- At time of surgery
- Radiographically
- Estimated

History of bowel lengthening surgical procedure: Yes ☐ No

Operative procedure used:
- STEP
- Non-STEP lengthening procedure
- Don’t know

Length prior to lengthening surgery: cm
Length after lengthening surgery: cm

☐ Enteral Nutrition Failure
- Inability to place EN tube
- Refusal of EN tube
- Inability to tolerate EN

☐ Post-operative Surgical Complications
Significant Comorbid Conditions

(check all that apply)

- Alcohol or drug addiction (past or current)
- Active Oncologic Process
- Active non-PN related infection
- Cirrhosis
- Chronic Kidney Disease
- Congestive Heart Failure
- COPD
- Diabetes
- Thyroid dysfunction
- Immunosuppression
- Neurologic disorder

Goals of PN therapy

Weight related goals (check all that apply):

- Weight gain for adults
- Growth for children
- Weight maintenance
- Weight loss (ex. obesity)

Non-weight related goals (check all that apply):

- Future surgery and re-establishment of GI anatomy
- Indefinite (permanent) HPN
- Resolution of GI issue and stopping HPN

PN, Nutrition and Medication

<table>
<thead>
<tr>
<th>PN Infusion</th>
<th>(please select)</th>
<th>days per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total volume in ml</td>
<td>per day or mL/kg/day</td>
<td></td>
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</table>
Total Dextrose in g: ___________ per day or ___________ g/kg/day
Total Protein as Amino Acids in g: ___________ per day or ___________ g/kg/day

Cycled over (please select) ___________ hrs

IV Fat Emulsion: (please select) ___________ days per week

IV fat emulsion dose: ___________ g per day or ___________ g/kg/day of fat infusion

Type of Fat Emulsion: select all that apply
- Soybean/Safflower
- Soybean only
- Emulsion containing Omega-3 fatty acids
- Other: ___________

**Medications**

(Check all that apply)
- Anti-depressants
- Anti-infectives
- Anti-inflammatory - NSAIDS
- Anti ulcer and acid supplements
- Biologic Response Modifiers
- Growth Hormone
- Glucagon- like peptide 2 (GLP-2)
- Insulin
- Glutamine
- Narcotics
- Octreotide
- Pre-Pro biotics
- Prokinetic Agents
- Steroids
- Thyroid hormone replacement
- Other Nutritional supplements

**Food and Diet**

(Check all that apply)
- NPO
- On concurrent enteral nutrition or breast milk via tube

What % calories come from enteral or breast milk via tube: ___________

What type of enteral formula is the patient on?

Name of product:
- Breast Milk
- Calciol
- Compleat Pediatric
- Elecare
- Fibersource
- Neocate
- Necate Infant
- Vivonex RTF
Catheter

Type of Central Venous Catheter
- PICC
- Port
- Tunneled
- Other: Please specify:

Lumen
- Single Lumen
- Double Lumen
- Triple Lumen

Date of Insertion (Please select)

Type of Catheter Flush or Lock (check all that apply)
- Heparin
- Ethanol
- Antibiotic
- Saline only
- Taurolidine

Catheter Used for Blood Draw
- Never
- Occasionally
- Often or Always
- Don’t Know

Signature: