**Supplementary Methods:**

We retrospectively analyzed 11 consecutive patients who underwent bedside PD catheter placement at our hospital from 4/1/2020 to 4/30/2020. AKI was defined as any patient with Acute Kidney Injury/Network (AKIN) stage 1 or greater and all patients in the cohort were AKIN stage 3. The nephrology consultant determined the need and the timing for RRT initiation based on usual clinical indications. These patients were then referred to the acute PD team composed of an attending nephrologist and surgeon to determine candidacy for bedside PD catheter placement. Patients were excluded for bedside PD catheter placement if they had significant abdominal surgical scars on exam, uncorrected hernias, high likelihood of prone ventilation, active gastrointestinal issues such as ileus or small bowel obstruction, or were on dual antiplatelet therapy with aspirin and clopidogrel. BMI greater than 30 $kg/m^2$ was a relative contraindication and candidacy was discussed on a case by case basis. Overall, 40 patients were screened and 11 were acceptable candidates for AKI-PD. All 11 patients underwent bedside placement of a swan neck double-cuff Tenckhoff tunneled PD catheter by our surgeons. Bedside placement of the catheters by a surgeon and an assistant alone was chosen to limit potential COVID-19 exposure of additional healthcare professionals, including anesthesia providers, nurses, and surgical or radiology technologists. Patients were deemed to have achieved renal recovery if they no longer needed any form of RRT as determined by the treating nephrologist.