

PATIENT QUESTIONNAIRE

The information which is requested on this form will be used for the sole purpose of matching a renal patient with a Renal Resource Peer (RRP) or Transplants Assisting Transplants (TAT) volunteer from the Kidney Foundation of Northwest Ohio. The information supplied on this form will be kept confidential and will be used only by KF staff.

ATTENTION SOCIAL WORKER OR HEALTH PROFESSIONAL:
UPON COMPLETION OF THIS FORM PLEASE CONTACT THE KIDNEY FOUNDATION BY PHONE AT 419-329-2196 OR FAX THIS FORM IN FULL TO 419-531-6080. THANK YOU.

PLEASE PRINT ALL INFORMATION:

NAME: _____
ADDRESS: _____

(CITY) (STATE) (ZIP)
PHONE: _(____)_____-_____
BIRTHDATE: ____/____/_____
(MM) (DD) (YYYY)
SEX: _____

WOULD YOU FEEL MOST COMFORTABLE WITH PEERS WHO ARE:
____ WITHIN 5 YEARS OF YOUR OWN AGE
____ ANY AGE
____ OTHER _____

ARE YOU: _____ CURRENTLY ON DIALYSIS
IF YES, _____ HEMODIALYSIS
(Please Circle) MWF TRS
____ CAPD
____ CCPD

APPROXIMATE DATE THIS BEGAN: _____
____ A TRANSPLANT RECIPIENT
DATE OF TRANSPLANT: _____
____ FAMILY MEMBER OF A RENAL PATIENT
PLEASE INDICATE RELATIONSHIP AND TYPE OF
TREATMENT PATIENT RECEIVES _____

INTERESTS: (Hobbies, Activities, Social Groups, Etc.) _____

DO YOU HAVE ACCESS TO TRANSPORTATION? _____

DO YOU HAVE ANY PHYSICAL LIMITATIONS? _____

WOULD YOU PREFER SESSIONS TO BE: _____ FACE-TO-FACE

**PREFERENCE:

____ YOUR HOME
____ PUBLIC PLACE

PLEASE LIST _____

____ TELEPHONE

****MAY WE GIVE YOUR
NUMBER TO PATIENT?
YES / NO**

****ARE YOU WILLING TO
PLACE A LONG DISTANCE
CALL TO PATIENT?
YES / NO**

**PLEASE INDICATE THE DAY(S) AND TIME(S) AT WHICH YOU WOULD BE AVAILABLE
TO SPEAK WITH A PATIENT.**

Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

Morning Afternoon Evening

ANY ADDITIONAL REQUESTS AND/OR COMMENTS? _____

Referring Social Worker or Health Professional

(MUST HAVE SIGNATURE): _____

Facility: _____

Phone Number: _____

COMMENTS: _____

FOR OFFICE USE ONLY

Date received: _____ Date referral made: _____