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
**PREFERANCE:
_____ 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: ____
____
____
____

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FOR OFFICE USE ONLY

Date received:_________________ Date referral made:___________________