



INTAKE FORM

Circle one: Miss Mrs. Ms. Mr. Dr. Other _____

Last Name _____ First _____ Gender _____

Telephone _____ DOB _____ County _____

Race _____ Marital Status _____ Start Date of ESRD _____ Current Treatment _____

Address, City, State, Zip Code _____

Current Employment _____ Retired/Past Employment _____

Nephrologist _____ Phone # _____ Dialysis Unit _____

Circle one: Left Right Arm Leg

Circle one: Fistula Graft Catheter Other

Days for Dialysis _____ Allergies _____

Medical Tag Information _____

Check the appropriate boxes below

_____ Please add my name to the Kidney Foundation mailing list so that I may receive the patient newsletter and other patient mailings.

_____ Please send information about Medical ID Tags.

I, hereby grant permission to the Kidney Foundation of Northwest Ohio to review information submitted above. I certify the information which is provided has been carefully reviewed by me and is true and correct. The information that has been provided may be released by the foundation to individuals, both professional and staff, working in the renal healthcare area as the Foundation deem appropriate, reasonable and necessary. This authorization and consent to disclose information may be revoked by the undersigned at any time by written notice.

Signature of Patient or Patient's
Authorized Representative

Date

Person Completing Form

Phone

Date