

## 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  
419-329-2784 OR FAX THIS FORM IN FULL AT 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 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 VOLUNTEER?

YES

NO

\*\*ARE YOU WILLING TO

PLACE A LONG DISTANCE

CALL TO VOLUNTEER?

YES

NO

PLEASE INDICATE THE DAY(S) AND TIME(S) AT WHICH YOU WOULD LIKE TO SPEAK WITH A VOLUNTEER.

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Morning							
Afternoon							
Evening							

ANY ADDITIONAL REQUESTS AND/OR COMMENTS? \_\_\_\_\_

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Referring Social Worker or Health Professional: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone Number: \_\_\_\_\_  
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**FOR OFFICE USE ONLY**

Date received: \_\_\_\_\_

Date referral made: \_\_\_\_\_

Name of volunteer used: \_\_\_\_\_