The Johns Hopkins Hospital
Kidney Transplant Program
600 North Wolfe St./ Osler 625 / Baltimore, MD 21287
Phone: 888-304-5069 opt. 1 / Fax: 443-529-1528

KIDNEY RECIPIENT INTAKE FORM

Name of Person Completing Form/ Relationship to Patient:

Name

Date of Birth

SSN

Telephone Numbers

Email Address

Mailing Address

Emergency Contact (Name, relationship, phone)

Interpreter Needed? If yes, list preferred language

Race

Gender

Mother's Maiden Name

Height

Weight

US Citizen?
Yes
No

Do you have Diabetes?
Yes
No

Organs Needed:
Kidney
Pancreas
Simultaneous Kidney and Pancreas

Are you considering live donation?
Yes
No

Do you currently have anyone committed to being tested as a kidney donor for you?
Yes
No

Have you been evaluated at another transplant center?
Yes
No

If yes, have you been:
Listed
Denied
On hold/ Deferred

If Previous Transplant, List Organ(s) Received:

Name of Previous Transplant Center:

Date of Previous Transplant(s)?

Referring Physician & Dialysis Information

Name & Address of Referring Physician

Telephone Number of Referring Physician

Do You Have a Primary Care Physician (PCP)?
Yes
No

If Yes, Name of Primary Care Physician

PCP Phone Number

Patient's Name

Are You Currently on Dialysis?	Weekly Dialysis Schedule	Dialysis Start Date	Dialysis Center's Information (Name of Center, Telephone Number & Address)
Yes No	Mon. Wed. Fri. Tues. Thurs. Sat. PD (Peritoneal Dialysis)		

Name of Primary Health Insurance Company & Telephone:

Subscriber's Name

Subscriber's DOB

Primary Insurance Policy Number:

Group #:

Name of Secondary Health Insurance Company & Telephone:

Subscriber's Name

Subscriber's DOB

Secondary Insurance Policy Number:

Group #:

Prescription Drug Coverage