The Johns Hopkins Hospital
Kidney Transplant Program
600 North Wolfe St./ Osler 625 / Baltimore, MD 21287
Phone: 888-3045069 opt. 1 / Fax: 443-529-1528

KIDNEY RECIPIENT INTAKE FORM

Patient's Information

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

US Citizen?

- ☐ Yes
- ☐ No

Organ(s) Needed

Do you currently have anyone committed to being tested as a kidney donor for you?

- ☐ Yes
- ☐ No

Previous Organ Transplants?

- ☐ Yes
- ☐ No

Previous Pregnancies?

- ☐ Yes
- ☐ No

Have You Ever Had a Blood Transfusion?

- ☐ Yes
- ☐ No
- ☐ Unknown

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

Patient's Name

Are You Currently on Dialysis?

- ☐ Yes
- ☐ No

Weekly Dialysis Schedule

- ☐ Mon. Wed. Fri.
- ☐ Tues. Thurs. Sat.
- ☐ PD (Peritoneal Dialysis)

Dialysis Start Date

Dialysis Center's Information (Name of Center, Telephone Number & Address)

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 #: