

Kidney Care and You

Please fill out this form and bring to your first appointment. Your answers will help us to tailor our support to your individual needs.

PATIENT INFORMATION LABEL

Name:

Address:

Phone:

Date of Birth (MM/DD/YYYY):

PHN:



QUESTIONNAIRE

1

Before you received this package, had you ever been told that you have a problem with your kidneys?

Yes No I'm not sure

2

What have you been told about your kidney problem?

3

Right now, I am most concerned with?

4

Other concerns I have are

5

Let us know of anything else you would like to share to help us get to know you better.
