Kidney Transplant Services Recipient Evaluation

Background Information Form/Social Worker Assessment

Please read before completing this form

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This form is intended for potential transplant recipients.

You may complete this form, to the best of your ability, and mail or fax to Presbyterian Transplant Services.

Address: Presbyterian Transplant Services
201 Cedar Ave SE, Suite 820
Albuquerque, NM 87106

Fax number: (505) 222-2149

Please use this as the cover sheet when sending completed form.

If you would like to speak with a Transplant team member before completing this form, please call **(505) 841-1434**.

Once we receive the completed form, a Transplant team member will contact you to complete a new patient intake and schedule you to attend the Transplant Orientation Class.

NAME:____________________________

Kidney Transplant Services Recipient Evaluation

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Instructions: Please fill out all the items on this form. Please print your name at the bottom right of each page.

PATIENT INFORMATION

Name: ____Date: ______________________

Address: ____________________________City: ________________State: _____Zip Code_______

Cell: _________________Work Phone: _______________ Home Phone: _____________________

Social Security #: __________________DOB: _______ Age: _________ Birthplace: _______________

Are you a US Citizen? ☐Yes ☐No Immigration Status: _______________________

Are you a Veteran? ☐Yes ☐No Type of Service____________________________________

Ethnicity: ________________ Race: _________________Religious Preference: _________________

Primary Language Spoken: _______________________ Language of Origin____________________

Relationship Status: ☐Single ☐Married ☐Life Partner ☐Divorced

Spouse/ Significant other's name: ________________________________ DOB: ________________

Emergency Contact: ____________________________ **Emergency Phone** #__________________

Relationship to emergency contact: ____

Do you live in: ☐House ☐Apartment ☐Mobile Home Do you: ☐Own ☐Rent

Who do you live with? (List Names & Relationships):

____

____

Do you have pets? ☐Yes ☐No Please list: ____

EMPLOYMENT AND EDUCATION

Highest Level of Education Completed: ____

Are you Currently Employed? ☐Yes_Where:___________________________________☐No

Position? _____________________For how long? ____________ ☐Full Time ☐Part Time

If no, when and where did you last work? ____

Reason for leaving: ____

Are you on disability? ☐ Yes ☐ No Type of benefit (SSD, SSI, etc.): ______________________

If so when was your disability start date: _______________Cause of disability: ______________________

Highest Level of education of your spouse/partner: ____

Is your spouse currently employed: ☐Yes ☐No Employer:_________________________________

INSURANCE INFORMATION

Primary Insurance Company: ____ID # ___________________

Secondary Insurance Company: ______________________________________ID # ___________________

Are any of your premiums paid by the American Kidney Fund (AKF) ☐Yes ☐No

Name of your drug prescription plan? _________________________ Medication co-pay?___________

Have you ever applied for, or been on Medicaid? ☐Yes ☐No

Do you have a living will? ☐Yes ☐No

RENAL MEDICAL HISTORY

Cause of your kidney failure? _________________________Date diagnosed______________________

Are you on dialysis? ☐Yes ☐No Type of dialysis: ☐Hemo ☐PD ☐Home Hemo

Dialysis Center:__________________________________ Date dialysis started: ______________________

How is dialysis going? ____

Do you or have you ever had a weight problem? ☐ Yes ☐ No If yes When:_____________________

Are you on a special diet? ☐Yes ☐No If yes, what kind? ☐Renal ☐Diabetic ☐Other __________

FAMILY INFORMATION

Mother's Name: ____ ☐Living ☐Deceased

Father's Name: ____ ☐Living ☐Deceased

Do you have brothers and sisters? ☐Yes ☐No

Names and ages of brothers and sisters? ____

____

Do you have children? ☐Yes ☐No

Name & Ages of Your Children: ____

____

Significant information about your children: ____

____

Describe your relationship with your family:____

Who do you most often look to for emotional support? ______________________________________

LIFESTYLE

How has your illness affected your lifestyle? ____

____

How do you cope with your illness and lifestyle changes? ____________________________________

____

What are your hobbies and activities? ____

What are the main causes of stress in your life? ____

____

How do you handle stress? ____

____

Have you ever been depressed? ☐Yes ☐No   Have you ever attempted suicide? ☐Yes ☐No

Have you ever had problems with anxiety? ☐Yes ☐No

Have you ever participated in counseling? ☐Yes ☐ No   If yes, When? _______________________

Why? ____________________________________ Was it helpful? ☐Yes ☐No

Do you currently use mood stabling drugs? ☐Yes ☐No   Did you in the past: ☐yes   ☐no

If yes what are they: ____

Are you open to counseling? ☐Yes ☐No

Have you even been hospitalized for psychiatric reasons? ☐Yes ☐No

Are you sexually active? ☐Yes ☐No   If yes, do you use protection/birth control? ☐Yes ☐No

What type of protection/ birth control do you use? ____

MEDICATIONS

Do you keep track of your own medications: ☐Yes ☐No

If no, who helps?____

☐ Self ☐ Spouse/Life Partner ☐Family Member ☐ Other

____

Do you know your medications? ☐Yes ☐No

Do you sometimes forget to take your medication? ☐Yes ☐No If yes, how Often: _______________

SUBSTANCE USE

Do you currently smoke or use tobacco products ☐Yes ☐No How much? ______________________

Have you ever smoked/chewed tobacco? ☐Yes ☐No For what time period _____________________

If yes, when did you quit_________________

Are you interested in a smoking cessation program? ☐Yes ☐No

Do you currently drink alcohol ☐Yes ☐No

Did you drink in the past? ☐Yes ☐No How Long? ___________ How much? ______________________

Have you ever had a DWI (Driving While Intoxicated/Impaired)? ☐Yes ☐No

Have you ever been called a "problem drinker" or "alcoholic"? ☐Yes ☐No

Have you ever participated in AA? ☐Yes ☐No

Have you ever been in court ordered treatment? ☐Yes ☐No

Do you use recreational drugs? ☐Yes ☐No Type (Pot, Crack, Cocaine, etc.) ___________________

Did you in the past? ☐Yes ☐No If yes, what and when? ___________________________________

Have you ever served time in jail/prison? ☐Yes ☐No

When? _____________ Why? ____

Have you ever been on Probation/Parole? ☐Yes ☐No

When? ____________________________________ Why? ____

POST-TRANPLANT CARE

Who will provide care and support to you during the transplant experience?

____

Who will care for you after your transplant? _______________________Relationship: ________________

Who will provide transportation after your transplant? ____________________Relationship: ___________

Does your support person have vacation time, or the ability to take a leave of absence, to assist you during and after your transplant? ☐Yes ☐No

If you live outside of the Albuquerque area, will staying in Albuquerque after your transplant be a financial strain for you? ☐Yes ☐No

Do you, or your family need assistance with lodging accommodations during your transplant recovery period? ☐Yes ☐No

What are your main concerns about being a candidate for a transplant? ____________________________

____

What are you hopes with getting a kidney transplant: ____

____

POTENTIAL DONOR(S)

Do you know anyone who wants to donate a kidney to you? ☐Yes ☐No

If yes, who and your relationship to them____

Are you comfortable accepting a living donor kidney? ☐Yes ☐No

Who filled out this background information form? ☐Self ☐Other _____________________________