

# KIDNEY TRANSPLANT

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

## FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
**If yes, use separate sheet to provide this information, including age of onset and date of death**

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of the transplant: \_\_\_\_\_

2.  Single or  multiple transplant?

3. What was the cause of the end stage renal disease which led to the transplant? (Cause for the transplant)

Diabetes  Glomerulonephritis  Nephrosclerosis  Systemic lupus erythematosus

Polycystic kidney disease  Other: \_\_\_\_\_

4. What was the source of the donor kidney?

Cadaver  Living related donor  Identical twin  Other: \_\_\_\_\_

5. Please give most recent results of kidney function tests:

BUN \_\_\_\_\_

Serum creatinine \_\_\_\_\_

Urinalysis \_\_\_\_\_

6. Have any of the following occurred (check all that apply):

Frequent infection  Rejection episodes  Toxicity from treatment  High blood pressure

Cardiovascular disease  Cancer  Disease recurrence

7. How often are checkups? \_\_\_\_\_

8. Are there any disabilities since the transplant?  No  Yes; please give details

9. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

10. Does client have any other major health issues? (additional questionnaires may be required)  No  Yes; please give details

