

Center: \_\_\_ Site: \_\_\_ Local ID#: \_\_\_\_\_

Interviewer Initials \_\_\_\_\_

### Chronic Kidney Disease in Children (CKiD)

### PATIENT CONTACT INFORMATION FORM

Form Version: 01 / 01 / 2005

Initials of Child: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Child: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Parent/  
Legal Guardian: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_  Not Available

Medical Records Number: \_\_\_\_\_  Not Available

Name of Healthcare Provider: \_\_\_\_\_  Not Available

Other Contacts (name and address of relatives/friends) in the event that the participant cannot be contacted directly:

Name 1: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name 2: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_