University of Washington Transplant Services

DEMOGRAPHIC INFORMATION
LIVING KIDNEY DONOR FORM

Last Name:_____First Name:_____Middle:_____

Name you prefer to be called:_____Relationship to recipient:_____

Circle one: Mr. Mrs. Miss Ms. Dr.

Street Address:_____Apt No.:_____

City:_____State:_____Country:_____Zip Code:_____-_____

Home Phone:_____Work Phone:_____Ext.:_____

Cell Phone: _____ Alternate Phone:_____

Social Security Number: _____-___-_____ Date of Birth: ___/___/___

Recipient Name: _____

Gender: [ ] Male [ ] Female

Citizenship: [ ] United States Citizen [ ] Resident Alien
[ ] Non-resident Alien [ ] Other

Ethnic Origin: [ ] Caucasian [ ] African American [ ] Middle-east/Arabian
[ ] American Indian [ ] Alaskan Native [ ] Asian
[ ] Indian Sub-continent [ ] Hispanic [ ] Other
[ ] Unknown

HIGHEST EDUCATIONAL LEVEL:
[ ] None [ ] Grade School (0-8)
[ ] High School (9-12) [ ] Attended College/Technical School
[ ] Associate/Bachelors Degree [ ] Post-College Graduate School
[ ] Unknown

LEGAL NEXT OF KIN

Name:_____Relationship to you:_____

Street Address:_____Apt No:_____

City, State, Zip:_____

Home Phone:_____Cell phone:_____Work Phone:_____

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University of Washington Transplant Services

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name:_____ Relationship to you:_____

Street Address:_____ Apt No:_____

City, State, Zip:_____

Home Phone:_____ Cell phone:_____ Work Phone:_____

EMPLOYER

Name:_____ Supervisor:_____

Street Address:_____ Dept.:_____

City, State, Zip:_____

Office Phone:_____ Ext.:_____ Office Fax:_____

PRIMARY CARE PHYSICIAN

Name:_____

Clinic Name:_____

Address:_____

City, State, Zip:_____

Office Phone:_____ Ext.:_____ Office Fax:_____