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

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

❑ Polycystic kidney 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

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