Participant Availability *(To be filled out by dialysis center staff)*

If a patient is currently unavailable or unable to respond on his/her own, we need to know why. Please fill out the following and return with the unused packet.
(*Please Print All Responses)*

Participant Information:
Current Information on File

Please make any corrections to
Address and Phone Number as needed

First Name: _____

Last Name: _____

Mailing Address: _____

City: _____

State and Zip Code: _____

Contact Phone #: ( ) - _____

Please check any of the following that apply to the patient listed above.

_____ Patient is deceased. Date of death: _____/_____/_____

_____ Patient has regained renal function.

_____ Patient has received a kidney transplant. Date of transplant: _____/_____/_____

_____ Patient has transferred to another dialysis unit.

_____ Patient does not speak English or Spanish.

_____ Patient is not capable of responding due to cognitive impairment.

_____ Patient is out of town. Anticipated date of return is: _____/_____/_____

_____ Patient is in the hospital. Anticipated return to unit is: _____/_____/_____

_____ Patient is on home dialysis. Please confirm the above address.