	Attention - DO NOT enter patient data on this form if the header does not contain <i>preprinted</i> HALT PKD ID number, clinical center ID, and visit number.						
PLI	Participant ID:	haltid	Clinical Center:	_ clinic	Date of Completion:_	/	/
PKD					month csm	day cs	d year cs y
vi	sit:						

CONTACT INFORMATION FORM

Form # 2

This is the <u>only</u> form linking a participant's personal identification with the study ID code. Contact information is to be collected at the pre-screening visit. <u>All</u> of the information on this form must be collected at the Baseline Visit and updated at each study visit, but the form itself need not be completed and must NOT be entered.

1.	Participant's Name:	: st, <i>Iname</i> Fir	st, fname	Middle <i>mname</i>	(Maiden) AKA:	
2.	Social Security Nur	nber:		.	.	-
3.	Preferred Method o	f Contact/Best Time	e(s):			
4.	Home Address:			Alternate Ado	dress:	
_	Street	Box/Apt.		Street		Box/Apt.
-	City	State	Zip	City		State Zip
5.	Phone Numbers: mphone sphone fphone	Home: () Work: () Mobile: () Alternate: ()		Fax: ()	
6. men	Email Addresses:	Home: Work: Alternat				
7.	Name of Spouse or	_	Last,	First,	Middle	(Maiden)

SVA	Attention - DO NOT enter patient data on this form if the header does not contain <i>preprinted</i> HALT PKD ID number, clinical center ID, and visit number.					
DVD	Participant ID:	_haltid	Clinical Center:	clinic Date of Completion:		/
vis	sit:			month csr	n day cso	d year cs y

CONTACT INFORMATION FORM

Form # 2

Home Phone (If different): ()	Work Phone ()					
Cell Phone: ()	Notes:					
8. Alternate Contact: Last, First	Relationship:					
Home Phone () (If different)	Work Phone:()					
Cell Phone: ()	- Notes:					
9. EMERGENCY CONTACT: #7 above	☐ #8 above ☐ Other (list below)					
Name: Relationship: _	Phone: ()					
	Alternate Phone Number()					
	· ·					
10. Primary Care/Referring Physician:						
Name: Nurse	/Contact:					
Address:						
Address: Street Bldg/Floor/Suite	Box/Dept.					
City	te Zip					
Phone: () Fax: ()	Notes:					
11. Nephrologist or Other Physician:						
Name: Nurse	/Contact:					
Address:						
Street Bldg/Floor/Suite	Box/Dept.					
City Sta	te Zip					
Phone: () Fax: ()	·					

	Attention - DO NOT enter patient data on this form if the header does not contain <i>preprinted</i> HALT PKD ID number, clinical center ID, and visit number.					
Participant ID:	haltid Clinical Center:	clinic Date of Completion: / / month csm day csd year cs y				
CONTACT INFORMATION FO	RM	Form # 2				
12. Notes:						

12. Notes:				_
				_
40.5				
13. Dates of I	_ast Update:			
//	Coord. Init	//	Coord. Init	 Coord. Init
	Coord. Init		Coord. Init	 Coord. Init
	Coord. Init		Coord. Init	 Coord. Init
	Coord. Init		Coord. Init	 Coord. Init
	Coord. Init		Coord. Init	 Coord. Init
	Coord. Init		Coord. Init	 Coord. Init

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HALT PKD staff member completing this form:		Date:/	/
	cmidnum	Month cdm Day cdc	1 Year cdv