Southern California Renal Disease Council INCORPORATED

Correction to Patient Census

Provider # _____

Facility Name: _____

	Last Name	First Name	SSN	DOB	Should Patient Be on Census? *(Please Check)*		Specify Reason ***If YES**: New Patient, Transfer In, Restart.* ***If NO**: Transfer out, Discontinue, Transplanted, Regained Function, Lost to Follow up, Death.* **If patient is **NOT** a patient at your facility, please specify.*	As of What Date? **Please remember, should reflect as of **12/31/2010***
					Yes	*No*		
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								