Methodist
DALLAS TRANSPLANT INSTITUTE

Application

Methodist Dallas Medical Center Recipient Application for Organ Transplant

All pages must be filled out completely and signed in order to process your application. If your application is incomplete, it will be returned to you, which will delay the processing of your request.

For assistance in filling out your application, please call 214-358-2300 ext. 5024.

Application for (check all organs that apply): ❑ Kidney ❑ Pancreas ❑ Liver

Possible donor sources: ❑ Living related ❑ Living unrelated ❑ Deceased donor

Who referred you to Methodist? ❑ Physician ❑ Insurance ❑ Self ❑ Other

PHYSICIAN INFORMATION

Your Kidney or Liver Doctor: _____ Phone: ( ) _____

Address: _____

Primary Care Physician: _____ Phone: ( ) _____

Address: _____

Would you like us to contact your physician by telephone? ❑ Yes ❑ No

PATIENT INFORMATION

Name: _____ SS#: _____
Last First Middle (Maiden) Social Security #

Mailing Address: _____
Street Address Apt. #

_____
City State ZIP

Home Phone: ( )Cell Phone: ( ) _____

DOB: _____ / _____ /Age:_____ Sex: _____

Religion: _____ Race: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Patient employed by:_____ Work phone: ( ) _____

Work Status: ❑ Full-Time ❑ Part-time ❑ Retired ❑ Disabled

Is patient a U.S. Citizen? ❑ Yes ❑ No If "no," what country? _____

Does patient speak English? ❑ Yes ❑ No If "no," what language?_____

SPOUSE OR PARENT (IF MINOR) INFORMATION

Name: _____ SS#: _____

Relationship to Patient: _____

Employer: _____ Work phone: ( ) _____

Alternate Contact Person:

Name:_____ Phone: ( ) _____

Relationship to Patient: _____

INSURANCE INFORMATION

MEDICARE I.D.: _____ Effective Date: ____ / ___ /_____

Medicare Due To (Check One): L Kidney Disease L Age

Social Security Disability: _____

MEDICAID I.D.: _____ Effective Date: ____ / ___ /_____

Texas Residents Only

Texas Kidney Healthcare I.D.: _____

INSURANCE COMPANY ONE

L HMO L PPO L POS L Indemnity Effective Date: _____ / __ / _____

Insurance Company Name: _____

Name of Group:_____

Group #: _____ Policy #: _____

Insurance Benefits Phone Number: ( ) _____

Insurance Company Address: _____

_____

Name of Insured Person: _____

Relationship to Patient: _____

Date of Birth of Insured: _____ / ____ / _____ SS# of Insured Person: _____

Other I.D. Number: _____

INSURANCE COMPANY TWO

L HMO L PPO L POS L Indemnity Effective Date: ____ /___ / _____

Insurance Company Name: _____

Name of Group:_____

Group #: _____ Policy #: _____

Insurance Benefits Phone Number: ( ) _____

Insurance Company Address: _____

_____

Name of Insured Person: _____

Relationship to Patient: _____

Date of Birth of Insured: _____ / ____ / _____ SS# of Insured Person: _____

Other I.D. Number: _____

DIALYSIS INFORMATION

Primary Diagnosis: _____

Currently on Dialysis? L Yes L No

Date Current Dialysis Began: _____ / ____ / _____

Type of Dialysis (Check One): L Home Hemo L PD L In-center Hemo _____

Dialysis Center: _____

Address: _____

Phone Number: ( ) _____

Dialysis Shift: L Mon Wed Fri L Tues Thurs Sat L 1 L 2 L 3 L 4

Previous organ transplant? L Yes L No

Organ Transplanted: _____

Date of Transplant: ____ / ___ / _____

Transplant Hospital: _____

_____ Date: ____ / ___ / _____

Signature

Mailing address:

Dallas Transplant Institute
Attention: Pre-Transplant Dept.
1420 Viceroy Drive, Dallas, TX 75235

Ph: 214.358.2300 • Fax: 214.366.6088

DALLAS TRANSPLANT INSTITUTE
PRE TRANSPLANT HEALTH HISTORY

Patient Name:_____
Date of birth: _____ Age: _____ Sex: M: ____ F: ____
Home phone number: _____Cell phone number: _____
Work phone number: _____May we contact you are work? □ Yes □ No
Additional phone numbers: _____
Emergency contact and phone number: _____
Married: ____ Single: ____ Divorced: ____ Widow(er): ____ Separated: _____
Do you speak English? □ Yes □ No
If NO, what language do you speak?_____

Ethnicity (Please check all that apply):

American Indian/Alaska Native		**Hispanic/Latino**		**Black or African American**	
	American Indian		Mexican		African American
	Eskimo		Puerto Rican (Living in US)		African (Continental)
	Aleutian		Puerto Rican (Island)		West Indian
	Alaska Indian		Cuban		Haitian
	American Indian or Alaska Native: Other		Hispanic/Latino: Other		Black or African American: Other
Asian		**Native Hawaiian/Other Pacific Islander**		**White**	
	Asian Indian/Indian Sub-Continent		Native Hawaiian		European Descent
	Chinese		Guamanian or Chamorro		Arab or Middle Eastern
	Filipino		Samoan		North African (non-Black)
	Japanese		Native Hawaiian or Other Pacific Islander: Other		White: Other
	Korean				
	Vietnamese				
	Asian: Other				

REFERRING PHYSICIAN INFORMATION

Nephrologist (Dialysis/Kidney Doctor):
Nephrologist's Telephone Number: _

Primary Care Doctor: _____
Primary Care Doctor's Telephone Number:

Are you on the waiting list at another transplant center? Yes: ____ No: _____
If yes - Where are you listed?_____ When were you listed?
Coordinator at that center? Coordinator's Phone#:

MEDICATIONS

List all medications (including dose and how often you take it):

_____
_____
_____
_____
_____
_____
_____

Please list all over the counter medications (examples: Tylenol, Advil) herbal supplements and vitamins you currently take:

_____
_____

Allergies:

_____

DIALYSIS AND TRANSPLANT HISTORY

What is the cause of your kidney failure? _____
Are you on dialysis? Yes: ____ No: ____ Date of First Dialysis: _____
Type of Dialysis: Hemodialysis: _____Peritoneal Dialysis: _____
If on hemodialysis - dialysis days: M – W – F: _____ T – Th – S: _____
Dialysis Center:
Dialysis Telephone Number:
Do you have frequent problems with your dialysis access? Yes: ____ No: ___
How often do you go to the hospital to have it fixed? _____
What is usually wrong with it?
Have you had a Previous Transplant? Yes: ____ No: _____
If yes, when and where were you transplanted: _____
Why did this transplant fail?
Are you interested in living kidney donation? Yes: ____ No: _____
Do you have potential living kidney donors? Yes: ____ No: _____
Who has offered to donate a kidney to you?_____

Social History

Do you currently smoke? Yes: ____ No: _____ _____ packs per day
How long have you smoked?_____When did you last smoke? _____

Have you ever smoked? Yes: ____ No: _____ _____ packs per day
How long did you smoke? _____ When did you quit? _____

Have you ever used illegal drugs? Yes: ____ No: _____
What type of drugs have you used? _____
When did you last use drugs?

How many meals do you eat? _____ per day
Amount of coffee? _____ cups per day. Amount of tea? _____ cups per day
Other caffeinated beverages (colas, energy drinks)? _____ per day
Do you currently consume alcoholic drinks? Yes: ____ No: _____
How many alcoholic drinks do you consume per day?_____ Per week? _____
When did you last consume alcohol? _____

Occupational Information

Your Occupation: _____
Are you currently working? Yes: ____ No: _____ Retired: _____
Are you working full time? Yes: ____ No: _____ Part time? Yes: ____ No: _____
How many hours/day? _____ Is your work stressful? Yes: ____ No: _____
Indoors: ____ Outdoors: ____ Is heavy lifting involved? Yes: ____ No: _____
What are the best days/times for appointments to be scheduled?_____
What days/times cannot be used to schedule appointments?_____

FAMILY HISTORY

	Age	Medical Problems	Cause of Death/Age at death (If no longer living)
Father			
Mother			
Brothers			
Sisters			
Sons			
Daughters			

Check if any of your blood relatives had any of the following:

Disease:	**Relationship to you**
☐ Diabetes	_____
☐ Heart Disease	_____
☐ Stroke	_____
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Malignancy/Cancer	
☐ Tuberculosis	_____
☐ Chemical Dependency	
☐ Other	_____

ADDITIONAL INFORMATION

Other Medical Problems:

_____

Have you had any surgeries? Yes: ____ No: _____
If yes, please list _____

Have you had any complications from anesthesia or surgery? Yes: ____ No: _____
If yes, please list _____

Have you had any other hospitalizations? Yes: ____ No: _____
If yes, please list _____

Are you willing to receive blood products if needed at time of transplant? Yes: ____ No: _____

GENERAL:

Your height is: _____ Your current weight is: _____
Is this your usual weight? Yes: ____ No: __

Please indicate any of the following that apply to your health condition in the past 6 months:

Weight Gain:	Yes: ____ No: ____
Weight Loss:	Yes: ____ No: ____
Fever:	Yes: ____ No: ____
Chills:	Yes: ____ No: ____
Night Sweats:	Yes: ____ No: ____

EYE, EAR, NOSE, AND THROAT *Check any that apply to you...*

Blindness	Yes: ____ No: ____
Glaucoma	Yes: ____ No: ____
Diabetic Retinopathy	Yes: ____ No: ____
Deafness/Hearing Loss	Yes: ____ No: ____

Any additional problems/surgeries/recent testing that you have had related to your eyes, ears, nose and/or throat:

_____

PULMONARY (Lungs) *Check any that apply to you...*

TB/Tuberculosis Yes: ____ No: ____
History of positive TB Skin Test Yes: ____ No: ____
If Yes – When and were you treated? _____
History of abnormal chest x-ray Yes: ____ No: ____
Chronic Bronchitis Yes: ____ No: ____
Asthma Yes: ____ No: ____
Emphysema/COPD Yes: ____ No: ____
Sleep Apnea Yes: ____ No: ____
Do you use CPAP? Yes: ____ No: ____
History of lung masses/nodules Yes: ____ No: ____
History of lung cancer Yes: ____ No: ____
Any additional problems/surgeries/recent testing that you have had related to your lungs:

Pulmonologist (Lung Doctor):
Pulmonologist's Telephone Number:

CARDIAC (Heart) and **VASCULAR** (Circulation) *Check any that apply to you...*

Hypertension/High Blood Pressure Yes: ____ No: ____
Frequent Fluid Overload/Congestive Heart Failure Yes: ____ No: ____
Coronary Artery Disease/Heart Disease Yes: ____ No: ____
Heart Attack Yes: ____ No: ____
Pacemaker Yes: ____ No: ____
Heart Surgery/CABG Yes: ____ No: ____
Valve Repair Yes: ____ No: ____
Angioplasty/PTCA Yes: ____ No: ____
Poor Circulation Yes: ____ No: ____
Pain in Legs When Walking Yes: ____ No: ____
Ulcers on Feet Yes: ____ No: ____
Amputations Yes: ____ No: ____
Bypass surgery for the Legs Yes: ____ No: ____
Additional problems/recent testing you have had related to your heart or circulation:

Cardiologist (Heart Doctor):
Cardiologist's Telephone Number:___
Vascular Surgeon:
Vascular Surgeon's Telephone Number:

GASTROENTEROLOGY (Abdomen/intestines/liver/stomach) *Check if any apply...*

History of Hepatitis B Yes: ____ No: ____
Have you received the Hepatitis B Vaccine? Yes: ____ No: ____
History of Hepatitis C Yes: ____ No: ____
Ulcer in stomach Yes: ____ No: ____
Ulcer in intestines Yes: ____ No: ____
History of Polyps Yes: ____ No: ____
History of Blood in Stools Yes: ____ No: ____
Diverticulosis Yes: ____ No: ____
History of vomiting blood? Yes: ____ No: ____
Problems with esophagus? Yes: ____ No: ____
History of intestinal problems? Yes: ____ No: ____
Have you ever had a colonoscopy (lower endoscopy)? Yes: ____ No: ____
When? _____ Why?_____
Have you ever had an EGD (upper endoscopy)? Yes: ____ No: ____
When? _____ Why?_____
Any additional problems/surgeries/recent testing that you have had related to your abdomen, intestines, liver, and/or stomach: _____
Gastroenterologist (Doctor for abdomen, stomach, liver and/or intestines):
_____

Gastroenterologist's Telephone Number:

NEPHROLOGY/UROLOGY (Kidney/bladder/ureter/urethra) *Check all that apply...*

Frequent Bladder Infections Yes: ____ No: ____
History of Kidney Infections Yes: ____ No: ____
Kidney Stones Yes: ____ No: ____
If yes, when?_____
History of Enlarged Prostate Yes: ____ No: ____
History of Bladder Surgeries Yes: ____ No: ____
If yes, why? _____
Have you had one of your kidneys removed? Yes: ____ No: ____
If yes, which kidney RIGHT: ____ LEFT: ____ BOTH: ____
Why? _____
Additional problems/surgeries/recent testing that you have had related to your kidneys, bladder, ureters, and/or urethra: _____

Urologist (Doctor for bladder/ureter/urethra/prostate):

Urologist's Telephone Number:

GYNECOLOGY (Breasts/Female Organs)

Date of last pap smear:_____ Date of last mammogram: _____
How many times have you been pregnant?
How many living children do you have? _____
How many miscarriages have you had? _____
Have you had a hysterectomy (uterus surgically removed) Yes: ____ No: ____
If yes, why? _____
Have you ever had an abnormal pap smear Yes: ____ No: ____
If yes, what was wrong? _____
Treatment for abnormal pap smear was _____
History of breast lumps or masses? Yes: ____ No: ____
Have you ever had an abnormal mammogram? Yes: ____ No: ____
If yes, what was wrong? _____
Treatment for abnormal mammogram was _____
History of breast biopsy? Yes: ____ No: ____
Additional problems/surgeries/recent testing that you have had related to your female organs:
_____

Gynecologist (Female Doctor):
Gynecologist's Telephone Number:

Breast Doctor: _____
Breast Doctor's Telephone Number:

MUSCULOSKELETAL *Check any that apply to you...*

Arthritis Yes: ____ No: ____
Joint Pain Yes: ____ No: ____
Joint Swelling Yes: ____ No: ____
Broken Bones Yes: ____ No: ____
Osteoporosis Yes: ____ No: ____

NEUROLOGY (Brain and Spinal Cord) *Check any that apply to you...*

Headaches Yes: ____ No: ____
Head Injury Yes: ____ No: ____
Seizures Yes: ____ No: ____
If history of seizures, please give date and cause: _____
CVA (Stroke) Yes: ____ No: ____
Spinal Cord Injury Yes: ____ No: ____
Paraplegic Yes: ____ No: ____
Quadriplegic Yes: ____ No: ____
Additional problems/surgeries/any recent testing that you have had related to your brain or spinal cord: _____

Neurologist (Brain Doctor): ____
Neurologist's Telephone Number:

ENDOCRINOLOGY (Diabetes or Thyroid) *Check any that apply to you...*

Diabetic: Yes: ____ No: ____
Age when diagnosed _____
Treated with Insulin? Yes: ____ No: ____
Medication Name_____ Dosage _____
Treated with Pills? Yes: ____ No: ____
Medication Name _____ Dosage _____
Hospitalizations related to your diabetes (Please give the date/name of hospital/and what problem(s) caused you to be hospitalized.) _____
_____

Thyroid nodule/masses Yes: ____ No: ____
Thyroidectomy/Thyroid surgically removed? Yes: ____ No: ____
If yes, when was surgery performed and why was this needed? _____

Endocrinologist (Diabetes/Thyroid Doctor):
Endocrinologist's Telephone Number: __

HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY
Check any that apply...

History of Bleeding Problems Yes: ____ No: ____
History of Difficulty Clotting Yes: ____ No: ____
Hemophilia Yes: ____ No: ____
Sickle Cell Disease Yes: ____ No: ____
Amyloidoisis Yes: ____ No: ____
Systemic Lupus Erythematosus Yes: ____ No: ____
Vasculitis Yes: ____ No: ____
Goodpastures' Disease Yes: ____ No: ____
History of swollen lymph nodes Yes: ____ No: ____
History of Cancer Yes: ____ No: ____
If yes, what type? _____
What treatment was done? _____
When was the cancer diagnosed? _____
Date of last treatment was _____
Have you ever had a blood transfusion? Yes: ____ No: ____
Total number of blood transfusions
When / where was the last blood transfusion? _____
Additional problems/surgeries/recent testing that you have had related to your blood problem or cancer:

Hematologist/Oncologist/Rheumatologist: _____
Hematologist/Oncologist/Rheumatologist's Telephone Number:

DERMATOLOGY *Check any that apply to you...*

Do you have any skin disorders? Yes: ____ No: ____
What kind? _____ _____
Dermatologist: _____ Telephone: ____

PSYCHOLOGICAL (Mental/Social) *Check any that apply to you...*

History of Mental Illness Yes: ____ No: ____
History of Alcohol/Substance Abuse Yes: ____ No: ____
Anxiety Yes: ____ No: ____
Depression Yes: ____ No: ____
Have you ever been incarcerated? Yes: ____ No: ____
Psychiatrist/Psychologist: _____
Psychiatrist/Psychologist's Telephone Number: _____

INFECTIOUS DISEASE (HIV)

Length of time on HIV treatment_____
Name and Number of Physicians you see for HIV
_____
Is your viral load undetectable? Yes:_____No:____

SPECIAL CIRCUMSTANCES, SITUATIONS AND CONCERNS

Are you the primary caregiver for a young child? Yes: ____ No: ____
What ages? _____
Are you the primary caregiver for an older adult? Yes: ____ No: ____
Do you have a car? Yes: ____ No: ____
Do you drive? Yes: ____ No: ____
If not, do you have someone else who can drive for you? Yes: ____ No: ____ Do you have special transportation issues that need to be considered? Yes: ____ No: ____

What are these transportation issues? (i.e.: bus transportation; scheduled community sponsored transportation) _____

Are you in school? Yes: ____ No: ____
Do you have any concerns / fears regarding a transplant?

What can we do to help with these concerns / fears?

Signature of patient: _____ Date:

If form not completed by patient:
Name of person completing form:
Relationship to patient:

Signature of person completing this form:

Dallas Nephrology Associates

Authorization for Release of Protected Health Information (PHI)

I hereby authorize _____ to release my PHI to Dallas Nephrology Associates as necessary during the time period of my medical evaluation for transplantation.

Patient Name _____ DOB

Address Phone

City/State/Zip _____SS#

For Healthcare Covering the Period(s) from _____to completion of medical evaluation and presentation to the transplant committee and/or listing on the transplant waiting list or receiving a living donor transplant. I understand that the contents of my medical record sent to Dallas Nephrology Associates at the beginning of the medical evaluation period will be included in this PHI.

- May include other healthcare providers' records? ☐ Yes ☐ No
- May records be faxed or electronically transmitted? ☐ Yes ☐ No

Information to be disclosed:

☐ Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records
☐ Social Worker assessments
☐ Billing Records
☐ Insurance Information
☐ Copy of all laboratory, diagnostic testing and x-ray reports

The purpose of these disclosures is for evaluation of medical suitability for kidney transplantation. These medical records will be reviewed by multiple physicians involved in the pre-transplant evaluation process as well as for insurance approval purposes to be listed on the transplant waiting list or for approval for a living donor transplant.

I understand that the information released as a result of this Authorization may be subject to redisclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this Authorization will expire in twelve months (12) from the date of signature. A photocopy of this Authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization upon request.

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

I understand that DNA cannot require me to sign this Authorization as a condition to providing services to me. I understand that I may inspect and/or copy this information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or DNA Privacy Officer.

_____ _____
Signature Date

_____
(Relationship or status if signed by anyone other than patient, parent or legal guardian, personal representative, etc)