TRANSPLANT APPLICATION

REQUIRED DOCUMENTS *(PLEASE PROVIDE A COPY OF THE FOLLOWING REQUIRED DOCUMENTS)*

- ☐ Copy of Government Issued I.D. such as Drivers License or Passport
- ☐ Copy of Insurance Card(s) – front and back
- ☐ Recent History and Physical from Nephrologist (within past year)
- ☐ Most Recent Height and Weight from Nephrologist or Dialysis Center

IF ON DIALYSIS

- ☐ Recent History of Compliance
- ☐ TB Test (within past year)
- ☐ Copy of HCFA 2728 Form

IF NOT ON DIALYSIS

- ☐ eGFR or 24 Hour Creatinine Clearance

The Transplant Institute
METHODIST DALLAS

Application

Methodist Dallas Medical Center Recipient Application for Organ Transplant

Application 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 214-947-1800 or toll-free 1-800-284-2185.

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

Possible living donor: ☐ Yes ☐ No

PHYSICIAN INFORMATION

Your kidney doctor: ______________________ Phone: ( ) ______________

Address: ____

Primary care physician: ______________________ Phone: ( ) ______________

Address: ____

PATIENT INFORMATION

Name: ______________________________________ SS#: ______________
LAST FIRST MIDDLE (MAIDEN) SOCIAL SECURITY #

Mailing address: ____
STREET ADDRESS APT. #

____
CITY STATE ZIP

Home phone: ( ) ______________ Mobile Phone: ( ) ______________

Email: ____

DOB: ______ / ______ / ______ Age: ______________ Sex: ______________

Religion: ______________________ Race: ______________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient employed by: ______________________ Work phone: ( ) ______________

Work Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled

Is patient a U.S. Citizen or permanent resident? ☐ Yes ☐ No If "no," what country? ______________

Does patient speak English? ☐ Yes ☐ No If "no," what language? ______________

ADDITIONAL CONTACT INFORMATION

Name: ______________________________ Phone: ( ) ______________

Relationship to patient: ____

MEDICARE/MEDICAID INFORMATION

MEDICARE I.D.: ______________________ Effective date: ______ / ______ / ______

Medicare Due To (Check One): ☐ Kidney disease ESRD ☐ Age ☐ other

Medicaid I.D.: ______________________ Effective date: ______ / ______ / ______

Texas residents only
Texas Kidney Healthcare I.D.: ____

Patient Name: ______________________________

INSURANCE

☐ HMO ☐ PPO ☐ POS ☐ Indemnity Effective date: ______ /______ /______

Insurance company name: ______________________________

Name of group/employer: ______________________________

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: ______________

Are you currently listed at another transplant center? ☐ Yes ☐ No Center Name: ______________

DIALYSIS INFORMATION

Primary diagnosis *(example: diabetes, FSGS, hypertension)* ______________________________

Currently on dialysis? ☐ Yes ☐ No

Date current dialysis began: ______ /______ /______

Type of dialysis (check one): ☐ Home hemo ☐ PD ☐ In-center hemo ______________

Dialysis center: ______________________________

Address: ______________________________

Phone number: ______________________________

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

Previous organ transplant? ☐ Yes ☐ No Organ transplanted: ☐ Kidney ☐ Pancreas ☐ Liver ☐ Other ______

Date of transplant: ______ /______ /______

Transplant hospital: ______________________________

______________________________ Date: ______ /______ /______

SIGNATURE

For assistance in filling out your application, please call 214-947-1800 or toll-free 1-800-284-2185.

Mail to: Methodist Dallas Medical Center
Kidney/Pancreas Transplant Program
PO Box 655999
Dallas, TX 75265-5999

Fax: 214-947-1828

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: (Please initial on appropriate line.)

_____Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records
_____ Copy of all health records to **exclude** 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)

Revised 9.15