BAYLOR
Annette C. and Harold C. Simmons Transplant Institute
Baylor University Medical Center at Dallas
Baylor All Saints Medical Center at Fort Worth
Now part of Baylor Scott & White Health

KIDNEY TRANSPLANT APPLICATION

I would like to be considered for: □ Kidney □ Kidney/Pancreas □ Pancreas Only

I would like to have my evaluation testing in: □ Dallas □ Ft. Worth □ Lubbock □ Amarillo

PATIENT INFORMATION	Name:		
Address: Apt #:	City: State: Zip:		
Social Security #:	Date of Birth:	Sex: □ Male □ Female	
Race: □ White □ Black □ Asian □ American Indian/Eskimo/ALEU □ Hawaiian Native/Pacific Islander □ Other			
Ethnicity: □ Hispanic Origin □ Not of Hispanic Origin			
Phone #: Cell #: E-mail:			
U.S. Citizen: □ Yes □ No	Language Preference:	Do you speak English: □ Yes □ No	
Emergency Contact:	Phone #:		

MEDICARE/MEDICAID INFORMATION (Please include a copy of all insurance cards)		
Medicare ID#:	Medicaid ID#:	Texas Kidney Health Plan #:

INSURANCE INFORMATION	
Primary Policy Holder's Name:	Date of Birth: Social Security #:
Insurance Company:	Customer Service #:
Policy / ID #:	Group #:

ADDITIONAL INFORMATION	Referring Physician:		
Address:	City: State: Zip:		
Phone #:	Fax #:		
Name of Dialysis Center:	Phone #: City:		
Dialysis Center Social Worker:			
Type of Dialysis: □ Not yet on dialysis □ Peritoneal □ Hemodialysis □ Home Hemodialysis		Height: Weight:	
Dialysis Days: □ M/W/F □ T/Th/Sat	Date of first dialysis:		
Previous Transplant: □ Yes □ No	If Yes, Transplant Center: City:	Date:	

PATIENT REQUEST TO BEGIN EVALUATION AND FINANCIAL CLEARANCE PROCESS

I request that Baylor All Saints (BAS), Baylor University Medical Center (BUMC) and Dallas Transplant Institute (DTI) begin the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start this process. I authorize my physicians to release my medical records to BAS, BUMC and DTI. I authorize BAS, BUMC and DTI to release any medical information pertaining to my diagnosis and/or treatment, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment, or any other such related information to: 1) Representatives of local, state or federal agencies in accordance with law; 2) Medicare; 3) Medicaid; 4) my insurance company or its designated representatives; 5) any person(s) or entities financially responsible for my care or treatment; 6) employees and/or representatives of BAS, BUMC and DTI for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against BAS, BUMC and DTI and/or any member of the medical and house staff at BAS, BUMC and DTI; and/or 7) individuals or entities for quality improvement, educational, medical research, accreditations or other purposes customarily utilized by hospitals and medical staffs in carrying out their functions. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for any medical expenses incurred at BAS, BUMC and DTI. I further authorize release of this information to health care providers associated with my care outside BAS, BUMC and DTI to facilitate further health care.

Patient Signature:	Date:
Print Name:	

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

Mailing Addresses for Baylor Annette C. and Harold C. Simmons Transplant Institute are:

Baylor University Medical Center in Dallas:
Dallas Transplant Institute
Attention: Pre-Transplant Dept.
1420 Viceroy, Dallas, TX 75235
Ph: 214.358.2300 • Fax: 214.366.6088

Baylor All Saints Medical Center in Fort Worth (Lubbock/Amarillo):
Baylor All Saints Medical Center
Attention: Pre-Transplant Dept.
1400 8th Avenue, Fort Worth, TX 76104
Ph: 817.922.4650 • Fax: 817.922.2310

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KIDNEY TRANSPLANT HEALTH HISTORY FORM

Today's Date:_____

Patient Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated

What is the cause of your kidney failure? _____

Do you have potential living donors? ☐ Yes ☐ No

Ethnicity (Please check all that apply):

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

REFERRING PHYSICIAN INFORMATION

Nephrologist (Dialysis/Kidney Doctor): _____ Telephone Number: _____

Primary Care Doctor: _____ 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: (attach an additional page if needed)

Medication Name	Dose	Frequency

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

Medication Name	Dose	Frequency

DRUG/FOOD ALLERGIES: _____

_____

GENERAL:

Your height is: _____ Your current weight is: _____ □ kg □ lbs Is this your usual weight? □ Yes □ No

Please check any of the following that apply to your health condition in the past 12 months:

□ Weight gain □ Weight loss □ Fever □ Chills □ Night sweats

Social History

Smoking history: Do you currently smoke? □ Never □ Current □ Previous If current: _____ packs per day; _____ years

If previous, how long did you smoke?_____ When did you quit?_____

Have you ever used recreational drugs? □ Yes □ No When did you last use drugs?_____

What type of drugs have you used? _____

_____

Do you currently consume alcoholic drinks? □ Yes □ No When did you last consume alcohol?_____

How many alcoholic drinks do you consume per day?_____ Per week?_____

Have you ever been incarcerated? □ Yes □ No Are you currently on probation? □ Yes □ No

Are you the primary caregiver for anyone? □ Yes □ No If so, who? _____

Do you have special transportation issues that need to be considered? □ Yes □ No

Occupational Information

Your Occupation:_____

Work status: □ Work full time □ Work part time □ Unemployed □ Disabled □ Retired □ Student

If working, is heavy lifting involved? □ Yes □ No Do you work outdoors? □ Yes □ No

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	_____
□ Other	_____

Check any that apply to you

EYE, EAR, NOSE, AND THROAT

- ☐ Blindness
- ☐ Glaucoma
- ☐ Diabetic Retinopathy
- ☐ Deafness/Hearing Loss

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

_____

_____

PULMONARY (Lungs)

- ☐ TB/Tuberculosis
- ☐ History of positive TB Skin Test
  If yes, when were you treated_____
- ☐ History of abnormal chest x-ray
- ☐ Chronic Bronchitis
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Oxygen Use
- ☐ Sleep Apnea
- ☐ CPAP Use
- ☐ History of lung masses/nodules
- ☐ History of lung cancer

Any additional problems/surgeries/recent testing that you have had related to your lungs:_____

_____

_____

Pulmonologist (Lung Doctor): _____
Telephone Number: _____

CARDIAC (Heart) **and VASCULAR** (Circulation)

- ☐ Hypertension/High Blood Pressure
- ☐ Frequent Fluid Overload/Congestive Heart Failure
- ☐ Coronary Artery Disease/Heart Disease
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Poor Circulation
- ☐ Pain in Legs When Walking
- ☐ Ulcers on Feet
- ☐ Amputations
- ☐ Blood clots/DVT

Additional problems/recent testing you have had related to your heart or circulation: _____

_____

_____

Cardiologist (Heart Doctor):_____
Telephone Number: _____
Vascular Surgeon: _____
Telephone Number: _____

GASTROENTEROLOGY (Abdomen/intestines/liver/stomach)

- ☐ Liver Disease
- ☐ History of Hepatitis B
- ☐ Received Hepatitis B Vaccine
- ☐ History of Hepatitis C
- ☐ Reflux/Heartburn
- ☐ Problems with swallowing
- ☐ History of vomiting blood
- ☐ History of intestinal problems
- ☐ Stomach Ulcer
- ☐ History of Polyps
- ☐ History of Blood in Stools
- ☐ Diverticulosis

Have you ever had a colonoscopy? ☐ Yes ☐ No
When? _____
Why? _____

(Gastroenterology continued)

Have you ever had an 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): _____
Telephone Number: _____
Hepatologist (Liver doctor):_____
Telephone Number: _____

NEPHROLOGY/UROLOGY (Kidney/bladder/ureter/urethra)

- ☐ Frequent Bladder Infections
- ☐ History of Kidney Infections
- ☐ Kidney Stones
  If yes, when_____
- ☐ History of Enlarged Prostate
- ☐ History of Bladder Surgeries
  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):

_____

Telephone Number: _____

GYNECOLOGY (Breasts/Female Organs)

- ☐ Have you had a hysterectomy (uterus surgically removed)
- ☐ Abnormal pap smear
- ☐ History of breast lumps or masses
- ☐ Abnormal mammogram
- ☐ History of breast biopsy

Date of last pap smear: _____
Date of last mammogram: _____
How many times have you been pregnant? _____
How many miscarriages have you had? _____
Additional problems/surgeries/recent testing that you have had related to your female organs: _____

_____

_____

Gynecologist(FemaleDoctor):_____
Telephone Number: _____

NEUROLOGY (Brain and Spinal Cord)

- ☐ Headaches
- ☐ Head injury
- ☐ Seizures
- ☐ Stroke
- ☐ Spinal Cord Injury

Additional problems/surgeries/any recent testing that you have had related to your brain or spinal cord: _____

_____

_____

Neurologist (Brain Doctor): _____
Telephone Number: _____

ENDOCRINOLOGY (Diabetes or Thyroid)

- ☐ Type 1 Diabetes; Age at diagnosis _____
- ☐ Type 2 Diabetes; Age at diagnosis _____
- ☐ Thyroid nodule/masses
- ☐ Thyroid surgically removed

Hospitalizations related to your diabetes (Please give the date/name of hospital/and what problem(s) caused you to be hospitalized.) _____

_____

_____

Endocrinologist (Diabetes/Thyroid Doctor):

_____

Telephone Number: _____

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Broken Bones
- ☐ Osteoporosis

HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY

- ☐ History of Bleeding Problems
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Amyloidoisis
- ☐ Systemic Lupus Erythematosus
- ☐ Vasculitis
- ☐ Goodpasture's Disease
- ☐ History of Cancer
  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
Additional problems/surgeries/recent testing that you have had related to your blood problem or cancer:_____

_____

_____

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

INFECTIOUS DISEASE (HIV)

Do you have HIV? ☐ Yes ☐ No
_____ If yes, length of time on HIV treatment: _____
Is your viral load undetectable? ☐ Yes ☐ No
Doctor Seen for HIV Treatment:_____
Telephone Number: _____

DERMATOLOGY

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

PSYCHOLOGICAL (Mental/Social)

- ☐ History of Mental Illness
- ☐ History of Alcohol/Substance Abuse
- ☐ Anxiety
- ☐ Depression

Psychiatrist/Psychologist:_____
Telephone Number: _____

ADDITIONAL INFORMATION

Do you have frequent problems with your dialysis access? □ Yes □ No

Other Medical Problems: _____

_____

_____

_____

Have you had any surgeries (not previously stated)? □ Yes □ No

If yes, please list _____

_____

_____

_____

Have you had any complications from anesthesia or surgery? □ Yes □ No

If yes, please list _____

_____

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

Have you had any hospitalizations within the past year? □ Yes □ No

If yes, please list _____

_____

_____

_____

SPECIAL CONCERNS

Do you have any concerns / fears regarding a transplant? _____

_____

_____

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

_____

_____