



Baylor Scott & White

ANNETTE C. AND HAROLD C. SIMMONS
TRANSPLANT INSTITUTE

BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS
BAYLOR SCOTT & WHITE ALL SAINTS MEDICAL CENTER – FORT WORTH

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 Longview

Fort Worth Lubbock Amarillo

| | | | | | |
|--|--|----------------------|----------|--|------|
| PATIENT INFORMATION | | Name: | | | |
| Address: | | Apt #: | City: | State: | Zip: |
| Social Security #: | | Date of Birth: | | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Eskimo/ALEU <input type="checkbox"/> Hawaiian Native/Pacific Islander <input type="checkbox"/> Other | | | | | |
| Ethnicity: <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Not of Hispanic Origin | | | | | |
| Phone #: | | Cell #: | E-mail: | | |
| U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Language Preference: | | Do you speak English: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Not yet on dialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Home Hemodialysis | | Height: | Weight: | | |
| Dialysis Days: <input type="checkbox"/> M/W/F <input type="checkbox"/> T/Th/Sat | | Date of first dialysis: | | | |
| Previous Transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No | | If Yes, Transplant Center: | | City: | Date: |

| | |
|---|-------|
| PATIENT REQUEST TO BEGIN EVALUATION AND FINANCIAL CLEARANCE PROCESS | |
| <p>I request that Baylor Scott & White All Saints Medical Center – Fort Worth (FW), Baylor University Medical Center, part of Baylor Scott & White (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 FW, BUMC and DTI. I authorize FW, 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 FW, BUMC and DTI for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against FW, BUMC and DTI and/or any member of the medical and house staff at FW, 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 FW, BUMC and DTI. I further authorize release of this information to healthcare providers associated with my care outside FW, BUMC and DTI to facilitate further healthcare.</p> | |
| Patient Signature: | Date: |
| Print Name: | |

| | | | |
|--|----------------------------|---|--|
| REQUIRED DOCUMENTS | | (Please provide a copy of the following required documents) | |
| <input type="checkbox"/> Copy of Government Issued I.D. such as Drivers License or Passport <input type="checkbox"/> Copy of Insurance Card(s) – front and back <input type="checkbox"/> Recent History and Physical from Nephrologist (within past year) <input type="checkbox"/> Most Recent Height and Weight from Nephrologist or Dialysis Center | If on Dialysis: | <input type="checkbox"/> Recent History of Compliance <input type="checkbox"/> TB Test (within past year) <input type="checkbox"/> Copy of HCFA 2728 Form | |
| | If Not on Dialysis: | <input type="checkbox"/> eGFR or 24 Hour Creatinine Clearance | |

Addresses for Baylor Scott & White
Annette C. and Harold C. Simmons
Transplant Institute applications are:

For Dallas and Longview:
Dallas Transplant Institute
Attention: Pre-Transplant Dept.
1420 Viceroy Drive, Dallas, TX 75235
Ph: 214.358.2300 • Fax: 214.366.6088

For Fort Worth, Lubbock and Amarillo:
Baylor Scott & White All Saints Medical Center - Fort Worth
Attention: Pre-Transplant Dept.
1400 8th Avenue, Fort Worth, TX 76104
Ph: 817.922.4650 • Fax: 817.922.2310



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 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 |
|---|--|---|--|--|---|
| <input type="checkbox"/> American Indian <input type="checkbox"/> Eskimo <input type="checkbox"/> Aleutian <input type="checkbox"/> Alaska Indian <input type="checkbox"/> American Indian or Alaska Native: Other | <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican (Living in US) <input type="checkbox"/> Puerto Rican (Island) <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic/Latino: Other | <input type="checkbox"/> African American <input type="checkbox"/> African (Continental) <input type="checkbox"/> West Indian <input type="checkbox"/> Haitian <input type="checkbox"/> Black or African American: Other | <input type="checkbox"/> Asian Indian/Indian Sub-Continent <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Asian: Other | <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Native Hawaiian or Other <input type="checkbox"/> Pacific Islander: Other | <input type="checkbox"/> European Descent <input type="checkbox"/> Arab or Middle Eastern <input type="checkbox"/> North African (non-Black) <input type="checkbox"/> 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 |
|-----------------|------|-----------|
| | | |
| | | |
| | | |
| | | |
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Please list all over the counter medications (examples: Tylenol, Advil) herbal supplements and vitamins you currently take:

| Medication Name | Dose | Frequency |
|-----------------|------|-----------|
| | | |
| | | |
| | | |
| | | |
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| | | |

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 |
|--|----------------------------|
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Malignancy/Cancer | _____ |
| <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> 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(Female Doctor): _____

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
- Amyloidosis
- 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? _____

