UT Southwestern Medical Center

UT Southwestern Kidney Transplantation Application and Recipient History

5939 Harry Hines Blvd.
Professional Building 1, Suite 920
Dallas, TX 75390-9258
Clinic – 214-645-1919
Fax – 214-645-1901

UT Southwestern Medical Record #: _____

PATIENT INFORMATION

Patient Name: _____ Maiden Name: _____ D.O.B.: _____

SSN: _____ Race: _____ Gender: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Are you a US Citizen? ☐ Yes ☐ No If No, what country? _____

Are you a legal resident? ☐ Yes ☐ No What is your primary language? _____

Driver's License Number: _____ State Issued: _____

Weight: _____ lbs. Height: _____ ft. _____ in.

Emergency Contact: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

What is your preferred UT Southwestern location? ☐ Dallas ☐ Lubbock ☐ Tyler

If you have a potential Living Donor, they can apply visiting this website: utswlivingdonor.org.

INSURANCE INFORMATION

Primary Insurance Company: _____ Insured's Name: _____

Insured's D.O.B.: _____ Insured's SSN: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Policy Number: _____ Group Number: _____ Eligibility Date: _____

Name of Employer: _____

Secondary Insurance Company: _____ Insured's Name: _____

Insured's D.O.B.: _____ Insured's SSN: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Policy Number: _____ Group Number: _____ Eligibility Date: _____

Name of Employer: _____

Disclosure of your Social Security Number (SSN) is requested from you in order for UT Southwestern to facilitate positive patient identification. No statute or other authority requires that you disclose your SSN for that purpose. Failure to provide your SSN, however, may result in a lack of positive patient identification. Further disclosures of your SSN are governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

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NEPHROLOGY (KIDNEY)

Name of Nephrologist: _____ Phone number: _____

Referring Physician: _____ Phone: _____

Dialysis Center: _____ Phone: _____

Type of Dialysis: ☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Home Hemodialysis ☐ Not yet on dialysis

Dialysis Days: ☐ M/W/F ☐ T/Th/Sat Dialysis Shift: ☐ 1st ☐ 2nd ☐ 3rd

Date of first dialysis treatment: _____

Have you been evaluated for transplant at another transplant center? ☐ Yes ☐ No

Are you currently on a transplant waitlist? ☐ Yes ☐ No

If Yes, name of transplant center: _____ Phone number: _____

Have you received a transplant previously? ☐ Yes ☐ No Location / Date: _____

List any additional problems/surgeries/recent testing you have had related to your kidneys: _____

_____

_____

GENERAL MEDICAL INFORMATION

Name of Primary Care Physician: _____ Phone number: _____

Have you been hospitalized in the last two years? ☐ Yes ☐ No Date of Admission: _____

Name and location of hospital: _____

Have you had any surgeries not already listed? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had a colonoscopy? ☐ Yes ☐ No

Name and location of colonoscopy: _____

Do you have diabetes? ☐ Yes ☐ No

If yes, for how many years? _____

Have you ever had an Echocardiogram? ☐ Yes ☐ No

Name and location of Cardiologist preforming Echo: _____

For female patients, date of your last Pap Smear: _____ Mammogram: _____

Name of Gynecologist: _____ Phone number: _____

Do you see any other physicians on a routine basis?

Physician Name: _____ Phone Number: _____

Physician Name: _____ Phone Number: _____

Physician Name: _____ Phone Number: _____

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PATIENT REQUEST TO BEGIN EVALUATION AND FINANCIAL CLEARANCE PROCESS

I request that UT Southwestern Medical Center begins the financial clearance process and transplant evaluation for me. I understand that my insurance company(ies) will be contacted in order to start this process. I authorize my physicians to release my medical records to UT Southwestern.

I authorize UT Southwestern 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 representatives of UT Southwestern for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against UT Southwestern, and/or any member of the medical and house staff at UT Southwestern; and/or 7) individuals or entities for quality improvement, educational, medical research, accreditation, 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 my medical expenses incurred at UT Southwestern. I further authorize release of this information to health care providers associated with my care outside UT Southwestern to facilitate further health care.

Authorization:
- ☐ Patient Signature
- ☐ Legal Representative (Proof of status as legal representative may be required)
- ☐ Verbal/Telephone/MyChart Confirmation Received (Receiving UTSW employee must sign with Title)

Patient or Legal Representative Printed Name	Signature	Date	Time AM/PM

Employee Printed Name and UTSW Title	Signature	Date	Time AM/PM

DIALYSIS CENTER ONLY

IMPORTANT! This application/health history must be filled out, signed and dated by the patient.

Please attach a copy of all insurance cards, and submit application along with the following medical records, if available:

- ○ Physician H&P
- ○ Progress Note
- ○ Recent Labs
- ○ Face Sheet
- ○ Patient Demographics
- ○ Copy of End Stage Renal Disease Medical Evidence report (2728 form – if on dialysis)
- ○ Vaccination Record
- ○ Social Work Assessment
- ○ Current Medication List
- ○ Renal Biopsy Report (if available)
- ○ Abdominal Sonogram Report (if available)

If you have any questions regarding this application, please contact UT Southwestern Kidney Transplant Clinic at 214-645-1919.

Please e-mail, fax or mail the application to:

UT Southwestern Kidney Transplant Program
5939 Harry Hines Blvd., POB 1, Suite 920
Dallas, Texas 75390-9258
214-645-1901 (Fax)
UTSWKidney@UTSouthwestern.edu (E-mail)