Texas Health Harris Methodist Hospital Fort Worth

Kidney Transplant Program

Transplant Application Packet

The following information should be included with the application:

1. Current application
2. History & physical from patient's nephrologist
3. Initial dialysis Social Worker evaluation
4. Initial dialysis Dietitian evaluation
5. Current lab results
6. Legible copy of insurance and identification cards (front & back): Medicare & Medicaid cards, prescription cards, Social Security cards, picture ID, resident card (if applicable)
7. Legible copy of patient's CMS 2728 form

If you wish to be considered as a potential recipient, please complete this application and return by mail, fax, or email to:

Texas Health
Harris Methodist Hospital®
FORT WORTH

Texas Health Harris Methodist Hospital Fort Worth
Kidney Transplant Program
1325 Pennsylvania Avenue, Suite 450
Fort Worth, Texas 76104

For questions, please call **817-250-2443** or **800-411-2443**.
Fax: **817-250-5136** Email: **THFWKidneyTransplant@TexasHealth.org**

Kidney Transplant Application

Last Name: _____ First Name: _____

Middle Name or Initial: _____ Maiden Name: _____

Address: _____ Apt #: _____

County / City / State / Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Would you like your appointment scheduled at our main office in ❑ Fort Worth, TX or ❑ Midland, TX (satellite clinic)?

Are you a: U.S. Citizen? ❑ Yes ❑ No Resident Alien/Greencard? ❑ Yes ❑ No Non-Resident Alien? ❑ Yes ❑ No

Date of Birth: _____ Age: _____ Sex: ❑ M or ❑ F Weight: _____ ❑ lbs. ❑ kg Height: _____ ❑ inch ❑ cm

SS #: _____ Marital Status: _____ Spouse Name: _____

Race: (check one) ❑ White ❑ Black ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Asian

❑ Pacific Islander ❑ Mid-East/Arabian ❑ Indian Sub-Continent ❑ Other

Primary language spoken: _____

Occupation: _____ Employer: _____

Work Phone: _____ May we contact you at work? ❑ Yes ❑ No

Employment Status: ❑ Full-time ❑ Part-time ❑ Disabled ❑ Not working ❑ Retired

Nephrologist (kidney doctor) or referring physician: _____ Dialysis Center: _____

Physician Phone: _____ Dialysis Center Phone: _____

First date of Dialysis: _____

Type of Dialysis (check one) ❑ Home HD ❑ Continuous Ambulatory PD ❑ Continuous Cycler-Assisted PD ❑ In-Center HD

Days of Dialysis (check one) ❑ M, W, F ❑ T, Th, S ❑ Other: _____ Dialysis shift (check one) ❑ 1st ❑ 2nd ❑ 3rd ❑ 4th

Previous transplant? ❑ Yes ❑ No If yes, list the organ type, date, and location: _____

_____

Phone numbers in case of emergency and relationship to patient:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Insurance Coverage: Please include legible copies of your insurance cards (front & back), including Medicare, Medicaid and Prescription benefits cards.

Medicare #: _____

Part A effective: _____ Part B effective: _____ Part D effective: _____

Part D Prescription Drug Plan (PDP): _____

Medicaid #: _____ Effective Date: _____

Texas Kidney Health #: _____ Effective Date: _____

PRIMARY INSURANCE

Primary Insurance Name: _____ ❑ PPO ❑ HMO ❑ POS

Claims Address: _____

Insurance Benefits Phone #: _____

Policy ID #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's SS #: _____ DOB: _____

Policy Holder's Employer: _____ Phone: _____

SECONDARY INSURANCE

Primary Insurance Name: _____ ❑ PPO ❑ HMO ❑ POS

Claims Address: _____

Insurance Benefits Phone #: _____

Policy ID #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's SS #: _____ DOB: _____

Policy Holder's Employer: _____ Phone: _____

PHARMACY INSURANCE

Prescription Benefits: _____

Prescription Drug Plan Name: _____ ID #: _____ Phone: _____

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Texas Health Harris Methodist Hospital® FORT WORTH

Completion of this application is required in order to start your evaluation.

I, _____ , give my permission to be contacted by the Texas Health Harris Methodist Hospital Fort Worth Kidney Transplant Program to receive more information about kidney transplant.

I understand that by submitting this application and giving my permission to contact me in no way guarantees that I will receive a kidney transplant.

_____ _____

Potential recipient's signature Date:

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____ **Phone Number:** _____

Other Names Used: _____ **Date of Birth:** _____ **Social Security Number:** XXX -_____ - _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR: PLEASE SELECT ONE OPTION

☐ Continuing Medical Care ☐ Military ☐ Personal Use ☐ School ☐ Insurance
☐ Legal Purposes ☐ Social Security/Disability ☒ Other: **Kidney Transplant Evaluation**

DATE(S) OF TREATMENT: _____

INFORMATION TO BE RELEASED OR ACCESSED:

☐ History & Physical ☐ Consultation Report ☐ Emergency Room Record
☐ Operative Reports ☐ Discharge/Death Summary ☐ Face Sheet
☐ Lab/Pathology Reports ☐ Radiology Reports ☐ Discharge Instructions
☐ Behavioral Health ☐ Radiology Images ☐ Other _____

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:

☐ Paper ☒ Electronic media* (requires 2 business days) ☐ Release to MyCare account (only applies to data stored electronically)

METHOD OF DELIVERY:

☐ Pick Up (You will be notified via a telephone call when records are ready for pick up)

☐ Mail to Address listed below ☒ **Fax to 817-250-5136**

_____**May release the above information to**:
(Hospital Name)

Texas Health Harris Methodist Hospital Fort Worth Kidney Transplant Program
(Name)

1325 Pennsylvania Ave., Suite 450, Fort Worth, TX 76104 / 817-250-2443 / FAX: 817-250-5136
Address (Street, State, Zip Code) Phone Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing Law.

This authorization will expire one hundred eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: _____.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____ _____
Relationship to Patient Printed Name of Patient or Legally Authorized Representative

_____
For Department use: MRN/Acct #

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FORT WORTH