

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
8. Any available records such as radiology scans or cancer screenings like mammogram, pap, and/or colonoscopy.

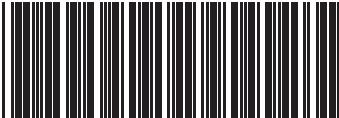
If you wish to be considered as a potential recipient, please complete this application and return by mail, fax, or email to:



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

For questions, please call **817-250-2443**.

Fax: **817-250-5136** Email: **THFWKidneyTransplant@TexasHealth.org**



TRNSPLNT



**KIDNEY TRANSPLANT PROGRAM
RECIPIENT APPLICATION ENGLISH**

ETHFW-0005 (04/22)

Page 1 of 5

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: _____

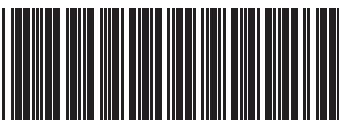
Type of Dialysis (check one) Home HD Continuous Ambulatory PD Continuous Cycler-Assisted PD In-Center HD

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 & Relation: _____ Phone: _____



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ETHFW-0005 (04/22)

Page 2 of 5

TRNSPLNT

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: _____



**KIDNEY TRANSPLANT PROGRAM
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ETHFW-0005 (04/22)

Page 3 of 5

TRNSPLNT

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

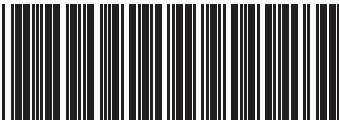
I, _____, give my permission to be contacted by the Texas Health Harris Methodist Hospital Fort Worth Kidney Transplant Program to receive more information about kidney transplant.

Yes, I DO **No, I DO NOT** As indicated, have chosen the following regarding receiving information from the Center and/or my physician via text messages. Texas Health offers the option to have messages sent to a number that I provide. Messages may include private information protected under federal and state law. I understand that text messages are not encrypted and are not secure. There is a risk that unprotected health information may be viewed by third parties. Fees may apply for the transmission of data and messages _____.

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:



**KIDNEY TRANSPLANT PROGRAM
RECIPIENT APPLICATION ENGLISH**

ETHFW-0005 (04/22)

Page 4 of 5

TRNSPLNT

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 #



AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

EXTHR239 (04/22)

Page 5 of 5