# KIDNEY AND KIDNEY/PANCREAS TRANSPLANT RECIPIENT APPLICATION

**LEGAL NAME:** ______________________________________________ **GENDER:** ☐ Male ☐ Female
(First) (MI) (Last) (Maiden)

ADDRESS: ______________________________________________ DATE OF BIRTH: ______________
(Street) (Apt #)

______________________________________________ MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED
(City) (State) (Zip)

SOCIAL SECURITY NUMBER: ___________-_______-__________ ALLERGIES: ________________________________________

TELEPHONE NUMBERS: Home- (______)___________ Cell- (_______)_________________ Work- (_______)_________________

HEIGHT: __________ WEIGHT: ___________ VISUAL IMPAIRMENT: Yes No HEARING IMPAIRMENT: Yes No

EDUCATION COMPLETED: 1st-8th grade High School/GED College 2 yrs College 4 yrs Graduate N/A

RACE: _______________________ U.S. CITIZEN: Yes No If No, how many years have you lived in the US? ________

ARE YOU OF HISPANIC ORIGIN: Yes No PRIMARY LANGUAGE SPOKEN: English Spanish Creole Other

CAN YOU READ ENGLISH: Yes No CAN YOU UNDERSTAND SPOKEN ENGLISH: Yes No

*IF YOU DO NOT SPEAK OR UNDERSTAND ENGLISH, WE WILL ARRANGE FOR A MEDICAL INTERPRETER FOR ALL APPOINTMENTS*

ARE YOU EMPLOYED: Yes No IF YES, DO YOU WORK: Full Time Part Time

## EMERGENCY CONTACTS:

Name: ________________________________ Name: ________________________________

Relationship: ________________________________ Relationship: ________________________________

Home Tel#: ________________________________ Home Tel#: ________________________________

Cell #: ________________________________ Cell #: ________________________________

## PHYSICIANS:

Primary Care: Name:________________________________ __________ Telephone #: (______)_________________

Nephrologist: Name:____________________________________________ Telephone #: (______)_________________

Cardiologist: Name:____________________________________________ Telephone #: (______)_________________

Other( GI/GU): Name: ___________________________________________ Telephone #: (______) _________________

Completed Application and Required records can be sent by mail or fax to:

By Mail: AdventHealth Transplant Institute
2415 North Orange Ave. Suite 700
Orlando Fl 32804

By Fax: 407-303-0894

## HEALTH HISTORY:

Please answer the following by putting a check mark in the appropriate box

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|---|---|---|---|---|---|
| High Blood Pressure | Yes | No | Sleep Apnea | Yes | No |
| Heart Disease | Yes | No | Asthma/Lung Disease | Yes | No |
| Cardiac Pacemaker | Yes | No | Tuberculosis | Yes | No |
| Stroke | Yes | No | Vascular Disease | Yes | No |
| Stomach Ulcer | Yes | No | High Cholesterol | Yes | No |
| Diabetes | Yes | No | Seizure Disorders | Yes | No |
| Do you use insulin? | Yes | No | Do you use Oxygen? | Yes | No |
| Use an insulin pump? | Yes | No | Do you use a walker? | Yes | No |
| What age were you diagnosed with diabetes? _______ | | | Do you use a wheelchair? | Yes | No |

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|---|---|---|---|---|---|---|---|---|
| Hepatitis A | Yes | No | Did you receive treatment? | Yes | No | Liver Biopsy? | Yes | No |
| Hepatitis B | Yes | No | Did you receive treatment? | Yes | No | Liver Biopsy? | Yes | No |
| Hepatitis C | Yes | No | Did you receive treatment? | Yes | No | Liver Biopsy? | Yes | No |

Name of Doctor who treated your Hepatitis: ______________________________________ Tel#: ( )________

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Have you had Cancer? Yes No If Yes, what type? ____________________________________________________

Date of Diagnosis? ____________________________________________________

Type of treatment? ____________________________________________________

Name of Doctor who treated your Cancer:________________________________________ Tel#: (_____)______________

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Blood Transfusions? Yes No If Yes, how many units? _______ Approximately when? _______________

Are you willing to receive blood transfusions if needed? Yes No

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Are you a smoker? Yes No If No, did you ever smoke? Yes No

If Yes, how many packs per day?____________ For how many years? _________

Do you drink alcohol? Yes No If Yes, how often? _________________________

Have you ever used recreational drugs? Yes No Are you currently using these? Yes No

Name(s) of recreational drugs used:________________________________________________________________________

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Do you take medication for anxiety or depression? Yes No

Name of Medication(s): ________________________________________________________________________________________

Are you currently under the care of a Psychiatrist or Psychologist? Yes No

Name of your Psychiatrist or Therapist: __________________________________________ Tel#: (_____)____________

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For Female Patients Only:

Number of pregnancies:__________ Is it possible for you to become pregnant? Yes No

Are you using birth control? Yes No What type of birth control do you use?_______________________

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Previous Surgeries/Hospitalizations: _________________________________________________Date: ____________________

_________________________________________________Date: ____________________

_________________________________________________ Date: ___________________

## KIDNEY DISEASE HISTORY:

What caused your kidneys to fail? ________________________________ Do you still make urine? Yes No

Have you started dialysis? Yes No If Yes, when did you start? Date: ____________________

Type of dialysis? Hemodialysis at a center Hemodialysis at home Peritoneal

If on Hemodialysis: what is your schedule? Mon-Wed-Fri Tues-Thurs-Sat Nocturnal (overnight)

what is your shift? 1st 2nd 3rd Nightly at home

Have you ever had a kidney biopsy? Yes No Date: _____________________

Name of Dialysis Center: ____________________________________________________ Tel#: (_____)________

Address: ____________________________________________________

City/State/Zip: ____________________________________________________

Have you had a kidney transplant? Yes No If Yes, how many?____________

Transplant #1 Living Donor Deceased Donor Transplant Date: ___________

Name of Transplant Center: ____________________________________________________

What side is the kidney on? Right Left Is it still in place? Yes No Failure Date: ___________

Transplant #2 Living Donor Deceased Donor Transplant Date: ___________

Name of Transplant Center: ____________________________________________________

What side is the kidney on? Right Left Is it still in place? Yes No Failure Date: ___________

Have you had any other transplant? Yes No What Type? __________________________

Name of Transplant Center: ________________________________ Date of Transplant: ____________________

Do you have a possible Living Donor? Yes No Do you still take Anti-Rejection medication? Yes No

Are you currently listed with another transplant center? Yes No If Yes, which one:____________________________

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## MEDICAL RECORD CHECKLIST: YOU MUST SUBMIT REQUIRED ITEMS LISTED BELOW FOR REFERRAL

- ☐ Recent Dictated (Typed) History and Physical, progress notes from your Nephrologist and Dialysis progress notes
- ☐ Laboratory Results from you Nephrologist or Dialysis Center (within 3 months)
- ☐ Copy of CMS 2728 Form (Required only if you are on dialysis. Ask your Dialysis Center to give you a copy)
- ☐ Legible copy of your Driver's License, Insurance card(s), and Drug Coverage card (front and back)

IF YOU HAVE ANY OF THESE ITEMS COMPLETED IN LAST 12 MONTHS PLEASE SUBMIT TO OUR TEAM.

- ☐ Pathology reports and medical records (Required for all patients with a reported history of cancer)
- ☐ Colonoscopy (Required for all patients 45 years of age and above. We will accept if done within last 5 years)
- ☐ Pap Smear (Required for FEMALE patients 18 years of age and above. Results must be within last 12 months)
- ☐ Mammogram (Required for FEMALE patients 40 years of age and above. Results must be within last 12 months)
- ☐ ***Cardiac Nuclear Stress Test (Required for ALL DIABETICS & PATIENTS OVER 50 YEARS OLD. Must be within last 12 months)
- ☐ ****Written Cardiac Clearance for transplant surgery from your Cardiologist (Results must be within last 12 months)
- ☐ ****If you have a cardiac pacemaker, please submit a copy of the Name, Model and Serial Number of the pacemaker
- ☐ Dialysis Social Worker Assessment (Required only if you are on dialysis)

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I have completed the application and enclosed all applicable items from the above checklist. I understand that physical examinations, financial, psychosocial and dietary assessments along with diagnostic and laboratory testing will be included as part of my transplant evaluation. Laboratory testing will include: HIV and Drug Screenings.

PATIENT/LEGAL GUARDIAN SIGNATURE: ____________________________________________DATE: _______________

Name of person filling out form if not the patient:____________________________ Relationship:__________________

## INSURANCE INFORMATION:

**PLEASE COMPLETE ALL SECTIONS**

LEGAL NAME: ____________________________________________________________ DATE OF BIRTH: _______________
(First) (MI) (Last) (Maiden)

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MEDICARE INFORMATION

Are you enrolled in Medicare? Yes No If No, are you eligible for Medicare? Yes No Unsure

If Yes, what is your Medicare Number: ________________________________

Is Your Medicare Coverage: Primary Secondary Third Pending Part A Effective Date:___________________ Part B Effective Date:____________________

Are you on Medicare because of kidney disease? Yes No If No, is your coverage due to? Age Another disability

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MEDICAID INFORMATION

Are you enrolled in Medicaid? Yes No If Yes, what is your Medicaid Number: ________________________________

Is Your Medicaid Coverage: Primary Secondary Third Pending

Are you enrolled as "Medically Needy"? Yes No If Yes, what is your monthly Share-of-Cost Amount? ______________

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OTHER INSURANCE (This includes employer group plans, purchased supplemental plans, and COBRA plans)

Insurance Company Name:___________________________________________________ Tel#: (_______)____________

Policy or Member ID#:_____________________________ Group #:________________ Effective Date: ____________

Is this an employer group health plan? Yes No If Yes, Employer Name?__________________________________

Are you the Policy holder? Yes No If No, Please answer the following:
Policy Holder Name: ________________________________________
Policy Holder Date of Birth:________________
Policy Holder Social Security Number: ________-________-________

Policy Type? HMO PPO POS Indemnity Supplemental Is this a COBRA Policy? Yes No

Is this Coverage: Primary Secondary Third Premiums are paid by?: Self Employer American Kidney Fund

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Insurance Company Name:___________________________________________________ Tel#: (_______)____________

Policy or Member ID#:_____________________________ Group #:________________ Effective Date: ____________

Is this an employer group health plan? Yes No If Yes, Employer Name?__________________________________

Are you the Policy holder? Yes No If No, Please answer the following:
Policy Holder Name: ________________________________________
Policy Holder Date of Birth:________________
Policy Holder Social Security Number: ________-________-________

Policy Type? HMO PPO POS Indemnity Supplemental Is this a COBRA Policy? Yes No

Is this Coverage: Primary Secondary Third Premiums are paid by?: Self Employer American Kidney Fun

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PRESCRIPTION DRUG COVERAGE

I have prescription drug coverage through: Medicare Part D Medicaid Private Insurance Veterans Administration
Member ID #:_____________________ Company Name:_____________________________ Tel#: (_____)_________

If prescription drug coverage is through the V.A., what is the location?_____________________ Team:_______________

# FINANCIAL AGREEMENT

(Please read this carefully)

Organ transplantation is an expensive undertaking that will require a serious commitment on your part. It represents a partnership between you, your physicians, and the transplant team. Paying for the transplant and the on-going care and medications required after transplant are important factors that need to be considered if you choose transplantation as a treatment option. Therefore, it is important for you to understand the terms and conditions of your current health insurance coverage and to be aware of any changes that may affect this coverage. When you submit your transplant application, one of our Transplant Financial Coordinators will verify your health insurance coverage and determine if you have benefits to cover transplant services at AdventHealth Orlando. If it is confirmed that you do have transplant benefit coverage, the Transplant Financial Coordinator will work on your behalf to obtain any necessary insurance authorizations required. Please be aware that it remains YOUR RESPONSIBILITY to notify the Transplant Financial Coordinator of ANY CHANGES TO YOUR HEALTH INSURANCE COVERAGE. If you make a change in insurance coverage YOU MUST send the Transplant Financial Coordinator a legible copy of your new health insurance card as soon as this change takes place. Failure to do so may jeopardize your ability to receive a kidney transplant at AdventHealth Orlando.
If you elect to change coverage, it is important to ensure that you select an insurance company that will cover your transplant and related care, including medications, at AdventHealth Orlando. Our Transplant Financial Coordinator can advise you on which insurance plans provide adequate coverage, as well as explain Medicare regulations as it pertains to End Stage Renal Disease. We STRONGLY advise you to opt for Medicare Part B, as well as Part A once your Medicare eligibility begins. Please be aware that if you have a potential living donor it will be imperative to have Medicare Part B as this will cover the medical charges ncurred by your living donor. Ultimately, YOU are financially responsible for the medical services you receive. If your insurance company does not cover transplant services at AdventHealth Orlando, or if there are co-pays and deductibles which are not covered by Medicare or your commercial health benefit plan, then you will be financially responsible for these payments. It is also Extremely Important that you maintain uninterrupted insurance coverage to ensure that your ongoing medical care and medications are covered.

If you have any questions or concerns regarding the financial aspect of your transplant care, please contact us at: 407-303-2474 and ask to speak to the Kidney Transplant Financial Coordinator

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AGREEMENT: Please read carefully and sign below

I understand that financial approval is based on my current health benefit insurance coverage and eligibility. If any changes occur related to this coverage, I agree to notify AdventHealth Transplant Institute within one week of the change. My failure to do so can result in an insurance denial and/or my personal financial liability for any and all charges associated with my transplant medical care. My signature below authorizes AdventHealth Transplant Institute to release information for purposes of obtaining financial approval for transplant services at AdventHealth Orlando and AdventHealth Transplant Institute. This may included physical assessments, mental health, substance abuse (e.g., drugs, alcohol), HIV/AIDS status information, diagnostic and treatment records. This may also include third party records received from you, or other healthcare providers sent on your behalf, to be used as part of your transplant evaluation.

I understand and accept the terms of this financial agreement.

| ______________________________ | ______________________________ |
|---|---|
| Print Patient Name or Legal Guardian | Date of Birth |
| ______________________________ | ______________________________ |
| Patient Signature or Legal Guardian | Date |

Please check one of the following:

ONLY CONTACT ME TO DISCUSS ANY FINANCIAL ISSUES RELATED TO MY TRANSPLANT BENEFITS

YOU MAY CONTACT THE FOLLOWING INDIVIDUAL TO DISCUSS ANY FINANCIAL ISSUES RELATED TO MY TRANSPLANT BENEFITS

Name: ____________________________________ Relationship: ______________________________ Tel#: ___________________

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****ALL INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE SENDER****