FLORIDA HOSPITAL
TRANSPLANT INSTITUTE
The skill to heal. The spirit to care.®

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 #:** (_____)_____

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

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

By Mail: Florida Hospital Transplant Institute
2415 North Orange Ave. Suite 700
Orlando, FL 32804

By Fax: 407-303-0677
407-303-2998

For Office Use Only: Medical Record #:_____

HEALTH HISTORY:

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

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	Are you on medication?	☐Yes ☐No
Use an insulin pump?	☐Yes ☐No	Name of medication?	_____
What age were you diagnosed? _____			

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#**: ( )_____

Have you had Cancer? ☐Yes ☐No If **Yes**, what type? _____

Date of Diagnosis? _____

Type of treatment? _____

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

Blood Transfusions? ☐Yes ☐No If **Yes**, how many units? _____ Approximately when? _____

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

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:_____

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#:** (_____)_____

For Female Patients Only:

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

Are you using birth control? ☐Yes ☐Nc What type of birth control do you use?_____

Previous Surgeries/Hospitalizations: _____

_____

_____

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

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:_____

MEDICAL RECORD CHECKLIST: ♦YOU MUST SUBMIT ALL REQUIRED ITEMS LISTED BELOW♦

- ☐ Recent Dictated (Typed) History and Physical from your Nephrologist
- ☐ Nephrologist Progress Notes
- ☐ Dialysis Progress Notes **(Required only if you are on dialysis)**
- ☐ Dialysis Social Worker Assessment **(Required only if you are on dialysis)**
- ☐ Recent Laboratory Results from you Nephrologist or Dialysis Center
- ☐ 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)**
- ☐ Complete "Insurance Information" Form **(page 4)** and sign "Financial Agreement" Form **(page 5)**
- ☐ Pathology reports and medical records **(Required for all patients with a reported history of cancer)**
- ☐ Colonoscopy **(Required for all patients 50 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

I have completed the application and enclosed all necessary items on 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)

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

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? _____

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

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

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:**_____

FLORIDA HOSPITAL
TRANSPLANT INSTITUTE
The skill to heal. The spirit to care.®

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 Florida Hospital. If is 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 Florida Hospital.

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 Florida Hospital. 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 eligibilty 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 incured 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 Florida Hospital, 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.

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 Florida Hospital 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 Florida Hospital Transplant Institute to release information for purposes of obtaining financial approval for transplant services at Florida Hospital and Florida Hospital 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#: _____