LasPalmaS MEDICAL CENTER
A Campus of Las Palmas Del Sol Healthcare

Transplant Services – Living Donor Application

Patient Information

Last Name:	**First Name:**	**Middle Initial:**	**Maiden Name:**
Social Security #:		**Date of Birth:**	
HOME Phone Number: ☐ ***None in the home***		**CELL Number:** ☐ ***None***	
HOME Address:		**MAILING Address:**	
City:	**State:**	**Zip Code:**	
WORK Phone Number:		**May we contact you at work? ☐ Yes ☐ No** **May we contact you by email? ☐ Yes ☐ No**	

Sex: ☐ Male ☐ Female	**Language Preference: ☐ English ☐ Spanish ☐ Other:**
Email address: ☐ ***None***	**Are you a U.S. citizen? ☐ Yes ☐No** **If no, please explain:**
Race/Ethnicity: ☐ American Indian ☐ Native Hawaiian ☐ Black or African American ☐ Asian ☐ White Hispanic/Latino: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other:	
Religion:	

Living Donor Relationship

Please provide information about the person you would like to donate to:

Last Name:		**First Name:**	
This person is my:			
☐ Mother **☐ Father** **☐ Brother** **☐ Sister**	**☐ Daughter** **☐ Son** **☐ Grandparent** **☐ Spouse**	**☐ Step-parent** **☐ Step-sibling** **☐ Cousin** **☐ Nephew**	**☐ Niece** **☐ Friend** **☐ Other:**

Personal Physician

Do you have a personal physician (PCP)? ☐ No ☐ Yes – please provide information		
Physicians Name:	**Phone Number:**	
Address:	**City:**	**State:**

Medicare

Do you have Medicare? ☐ No ☐ Yes

Medicaid

Do you have Medicaid? ☐ No ☐ Yes

Private/Commercial Insurance

Do you have Private Insurance? ☐ No ☐ Yes

Personal Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Live-in partner ☐ Widowed	**Years Married or Together:**
Total Monthly Income: $	**Number of people in household:**
Highest completed education level: ☐ None ☐ Some college ☐ Grade school (K-8) ☐ Associates or Bachelors ☐ Some High School (9-11) ☐ Graduate degree or higher ☐ High School degree ☐ Other:	**Are you currently attending school?** ☐ No ☐ Yes **Name of School:**

Employment Status

Are you working?

☐ Not Working	☐ Disability ☐ Health or Demands of dialysis ☐ Student ☐ Homemaker / Caregiver ☐ Retired		
☐ Working	☐ Working Full time ☐ Working Part time: ☐ Disability ☐ Health or Demands of dialysis		
Employer:	**Job title:**		**Years employed:**
Address:	**City:**	**Phone:**	

Emergency Contacts

Primary Contact			**Alternate Contact**		
Name:	**Phone:**		**Name:**	**Phone:**	
Address: ☐ Same as living donor			**Address:** ☐ Same as living donor		
City:	**Zip:**		**City:**	**Zip:**	
Relationship:			**Relationship:**		

Medications

Current Medications: *List all medicines that you are currently taking including: prescribed drugs, over-the-counter drugs, vitamins, and inhalers).* ☐ **Not taking any medications**

Name of Drug:	Strength:	Frequency Taken:	Date Started:

List any **medications or foods** *that you are* **allergic** *to and the reaction you experienced from taking them*

☐ **No Known Drug Allergies**

Name of Drug:	Reaction You Had:

Health Habits and Personal Safety

Exercise:	☐ **Sedentary** (no exercise) ☐ **Mild** exercise (climb stairs, frequent walk, golf) ☐ **Occasional vigorous** exercise (less than 4 times per week for 30 min.) ☐ **Regular vigorous** exercise (more than 4 times per week for 30 min.)			
Diet:	Do you have a **visual** problem (e.g. glasses, blindness)?	☐Yes ☐No		
	Do you have a **hearing** problem (e.g. hearing aid, deafness)?	☐Yes ☐No		
	Do you have **difficulty reading or writing**?	☐Yes ☐No		
	Do you have difficulty with **speech** (e.g. speech impediment)?	☐Yes ☐No		
Sexual Activity: FEMALES ONLY	Are you trying for pregnancy?....	☐Yes ☐No		
	If **no,** please list contraceptive or barrier method:			
Personal Safety:	Do you live alone?.....	☐Yes ☐No		
	Do you have an Advance Directive and/or Living Will?	☐ Yes ☐No		
Alcohol and Drug Use:	Do you currently use **alcohol**?	☐Yes ☐No	Date of last use: _____/_____	
	How many years have you used / did you use?	Yrs:	Type:	
	Do you currently use **tobacco**?	☐Yes ☐No	Date of last use: _____/_____	
	How many years have you used / did you use?	Yrs:	Type:	
	Do you use **illicit drugs**? Examples: marijuana, cocaine, heroin, illegal steroids	☐Yes ☐No	Date of last use: _____/_____	
	How many years have you used / did you use?	Yrs:	Type:	
	How frequently do / did you use illicit drugs?	☐ Daily	☐Weekly	☐ Monthly

Personal Health Information

History Of Medical Illnesses:	Illness:	Age at Onset:	Illness:	Age at Onset:
	☐ Diabetes ☐Type 1 ☐Type 1I		☐ Osteoarthritis	
	☐ Hypertension		☐ Gout	
	☐ Heart Disease		☐ Bleeding Disorder	
	☐ Asthma		☐ Epilepsy	
	☐ Cancer		☐ Severe infection	
	☐ Lupus		☐ Osteoporosis	
	☐ Fibromyalgia		☐ Other:	

Personal Health Information

Height:		**Weight:**		
Anesthesia	Have you had any negative reactions to anesthesia?		☐ Yes ☐No	
	If yes, what was the problem:			
Blood Transfusion	Have you ever had a blood transfusion?		☐ Yes ☐No	
	If yes, what are the dates?			
Chronic Infection	Do you have a chronic infection of any type?		☐ Yes ☐No	
	If yes, list what it is and when:			
Infection Risks	Have you ever had a tattoo?.....		☐ Yes ☐No	
	If yes, state when:			
	Have you ever had a body piercing?.....		☐ Yes ☐No	
	If yes, state when:			
	Have you ever had acupuncture?.....		☐ Yes ☐No	
	If yes, state when:			
	Have you ever tested positive for any of the following STDs:			
	Chlamydia ☐ Yes ☐No		Herpes ☐ Yes ☐No	
	Gonorrhea ☐ Yes ☐No		Syphilis ☐ Yes ☐No	
	Have you been treated for <u>any</u> infection in the past 12 months?.....		☐ Yes ☐No	
	If yes, state when and the type:			
	Have you or do you have sex with multiple partners?.....		☐ Yes ☐No	
	Where were you immunized? ☐ United States ☐ Mexico ☐ Other			
	Have you had any recent vaccinations?.....		☐No ☐ Yes – When?	

*The following information is a review of your **overall** health. Please provide any comments at the end of each section that you feel would help us better understand your health in that area*

Personal Health Information

Neurology (Brain and Spinal Cord)	***Do you regularly have any of the following problems?***	
	Headaches	☐ Yes ☐ No
	Seizures	☐ Yes ☐ No
	Back pain	☐ Yes ☐ No
	Have you had a head injury?	☐ No ☐ Yes – When: _____
	Do you have numbness or tingling in your arms or legs?	☐ Yes ☐ No
	If yes, state where: _____	
	Comments:	
	Do you have a Neurologist (Brain doctor)?	☐ Yes ☐ No
	If yes, state who: Dr. _____	
Eye, Ear, Nose and Throat	Do you regularly experience sinus infections?	☐ Yes ☐ No
	Comments:	
Cardiac (Heart)	High Blood Pressure	☐ Yes ☐ No
	Heart disease	☐ Yes ☐ No
	Heart attack	☐ Yes ☐ No
	Pacemaker	☐ Yes ☐ No
	Heart surgery	☐ Yes ☐ No
	Heart palpitations	☐ Yes ☐ No
	Comments:	
	Do you have a Cardiologist (Heart doctor)?	☐ Yes ☐ No
	If yes, state who: Dr. _____	
Pulmonary (Lungs)	Sleep Apnea	☐ Yes ☐ No
	COPD	☐ Yes ☐ No
	TB/Tuberculosis	☐ Yes ☐ No
	If yes, dates of treatment: _____ Where treated?	
	Bronchitis	☐ Yes ☐ No
	Asthma	☐ Yes ☐ No
	Wheezing or Shortness of breath	☐ Yes ☐ No
	History of emphysema	☐ Yes ☐ No
	History of lung masses/nodules	☐ Yes ☐ No
	History of lung cancer	☐ Yes ☐ No
	Comments:	
	Do you have a Pulmonologist (Lung doctor)?	☐ Yes ☐ No
	If yes, state who: Dr. _____	

Personal Health Information

Endocrinology (Diabetes or Thyroid)	Are you diabetic?	☐No ☐ Yes	If yes, what type: ☐ I ☐ II
	Does anyone in your family have diabetes?		☐ Yes ☐No
	If yes, please list the relationship:		
	Do you have thyroid problems?		☐ Yes ☐No
	Comments:		
	Do you have an Endocrinologist (Diabetes/Thyroid doctor)?		☐ Yes ☐No
	If yes, state who: Dr. _____		
Gastroenterology (Abdomen/Intestines/ Liver/ Stomach)	History of Hepatitis A, B, or C		☐ Yes ☐No
	If yes, check the type of Hepatitis you had: ☐ A ☐ B ☐ C ☐ Unknown		
	Ulcer in stomach and/or intestines		☐ Yes ☐No
	History of blood in stools		☐ Yes ☐No
	History of gallstones/gallbladder problems		☐ Yes ☐No
	Diverticulosis		☐ Yes ☐No
	History of vomiting blood		☐ Yes ☐No
	Problems with esophagus		☐ Yes ☐No
	History of diarrhea		☐ Yes ☐No
	History of constipation		☐ Yes ☐No
	Have you ever had a colonoscopy or EGD?		☐ Yes ☐No
	If **yes**, give the **reason** why and the **date** performed: Colonoscopy: _____ _____/____/_____ EGD: _____ _____/____/_____		
	Comments:		
	Do you have a Gastroenterologist (Abdomen/Stomach/Liver doctor)?		☐ Yes ☐No
	If yes, state who: Dr. _____		

Personal Health Information

Urology (Kidney/ Bladder/ Ureter/ Uretha)	Frequent bladder infections	☐ Yes ☐No
	Painful urination	☐ Yes ☐No
	Difficult to urinate	☐ Yes ☐No
	Urinate frequently	☐ Yes ☐No
	Lose control of bladder when you cough, laugh, or sneeze	☐ Yes ☐No
	History of kidney infections	☐ Yes ☐No
	History of kidney stones	☐ Yes ☐No
	History of enlarged prostate	☐ Yes ☐No
	History of bladder surgeries	☐ Yes ☐No
	Do you have a Urologist (Kidney/Bladder/Ureter/Uretha)?	☐ Yes ☐No
	If yes, state who: Dr. _____	
Hematology Oncology Rheumatology (Blood/ Cancer)	History of bleeding problems	☐ Yes ☐No
	History of difficulty clotting	☐ Yes ☐No
	Frequent bruising	☐ Yes ☐No
	Blood clots in legs or lungs	☐ Yes ☐No
	Frequent nosebleeds	☐ Yes ☐No
	Problems keeping your balance	☐ Yes ☐No
	History of bone fractures	☐ Yes ☐No
	Do you have arthritis?	☐ Yes ☐No
	Do you have muscle or joint pains?	☐ Yes ☐No
	Do you have a family history of cancer?	☐ Yes ☐No
	If **yes**, list what **relative** and **type of cancer**: Relative: _____ Type:_____ Relative: _____ Type:_____	
	Do you have a history of cancer?	☐ Yes ☐No
	If yes, please list dates: _____ Type: _____ Treatment: ☐ Radiation ☐ Chemotherapy	
	Do you have a Hematologist/Oncologist/Rheumatologist?	☐ Yes ☐No
	If yes, state who: Dr. _____	

Psychosocial (Mental/Social)	History of Mental Illness	☐ Yes ☐No
	Have you ever been incarcerated/in jail?	☐ Yes ☐No
	History of anxiety	☐ Yes ☐No
	History of depression	☐ Yes ☐No
	Have you been hospitalized for mental illness?	☐ Yes ☐No
	If yes, provide dates of hospitalization:	
	Do you have a Psychiatrist or Psychologist?	☐ Yes ☐No
	If yes, state who: Dr. _____	
FEMALES ONLY		
Gynecology	Have you had a hysterectomy?	☐ Yes ☐No
	If yes, provide date: _____	
	Date of your last Pap Smear: _____/____/_____	
	Have you ever had an abnormal Pap Smear?	☐ Yes ☐No
	Date of last Mammogram: _____/____/_____	
	Have you ever had an abnormal Mammogram?	☐ Yes ☐No
	Do you have a Gynecologist?	☐ Yes ☐No
	If yes, state who: Dr. _____	
	How many times have you been pregnant?	☐ None ☐#_____
	If you have been pregnant, answer the following questions:	
	How many live births have you had?	#_____
	Was your blood pressure elevated during pregnancy?	☐ Yes ☐No
	Did you have gestational diabetes?	☐ Yes ☐No

Surgical History

Have you had a kidney removed? ☐ Yes ☐No	**If yes, list date: _____**

List any surgeries that you have had: ☐ **NONE**

Surgery:	Reason:	Date:

List any recent hospitalizations that you have had in the last 6 months: ☐ **NONE**

Reason for Hospitalization:	Date:

Dental Information

Dental	When was your last dental exam? _____/____/_____	
	Do you have dentures?	☐ Yes ☐No

Family History Information

Please provide the following information for following individuals.
Mark with an X the diseases that you are aware of in your family history.

Do relatives have history of:	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Brothers	Sisters
Diabetes								
Kidney Disease								
Kidney Stones								
Hypertension								
Cancer								
Heart Disease								
Stroke								
Lupus								
Mental Illness								
Age at Death:								

Patient Signature:	
Printed Name:	**Date:**
Signature:	

--TRANSPLANT SERVICES USE ONLY--

Review of Application

Date:	**Signature:**

Section A: This section must be completed for all Authorizations

Patient Legal Name:	**Birth Date:**	**Social Security No. *(optional)*:**
Patient Address:	**Patient Telephone No:**	
City: **State:**	**Zip Code:**	

I hereby authorize Las Palmas Del Sol Healthcare to disclose medical record information and / or protected health information of the patient listed above to:

Name/Title: Las Palmas Medical Center – Transplant Services

Address: 1700 N. Oregon, Ste. 680	**City:** El Paso	**State:** TX	**Zip:** 79902

Purpose of disclosure:

For treatment date:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**
Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description of information to be used or disclosed

☒ Copies of the record ☒ Inspection of the record ☐ Letter for dates of service	☒ Las Palmas ☐ Del Sol	☒ **Entire Record** ☐ Rehab ☐ Physical Therapy ☐ Oncology Center ☐ Life Care Center ☐ Wound Care Center ☐ Diagnostic Center ☐ Women's Health Center ☐ Dx/Abstract Pertinent Information	☐ Emergency Room Report ☐ ER discharge instruction sheet ☐ Discharge Summary ☐ H & P ☐ Consult Report ☐ Operative Report ☐ Respiratory Report ☐ Lab	☐ Imaging/ Radiology ☐ Cardiac Studies ☐ Face Sheet ☐ Nursing Notes ☐ Medication Record ☐ Registration Consents ☐ Progress Notes ☐ Physician Orders ☐ Other_____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? If yes, describe:	☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/ Representative:	**Date:**
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient:**

Authorization for Release of Protected Health Information (PHI)