Transplant Services - Recipient

Patient Information

Last Name:	First Name:	Middle Initial:	Maiden Name:
Social Security #:	Date of Birth:		Sex: ☐ Male ☐ Female
HOME Phone Number: ☐ *None*	CELL Number: ☐ *None*		
HOME Address:	MAILING Address: ☐ *Same as Home Address*		
City:	State:	Zip Code:	
WORK Phone Number: ☐ *None*	Language Preference: ☐ English ☐ Spanish ☐ Other:		
Email address: ☐ *None*	☐ U.S. Citizen ☐ Non-U.S. Citizen/Resident ☐ Visa		
Race/Ethnicity: Hispanic/Latino: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other: ☐ American India ☐ Native Hawaiian ☐ Black or African American ☐ Asian ☐ White			

Nephrologist / Kidney Specialist Doctor

Physicians Name:	Phone Number:	
Address:	City:	State:

Dialysis

Are you currently on dialysis? ☐ No ☐ Yes – please provide information		
DIALYSIS CENTER INFORMATION		
Name of Center:	Phone Number:	
Address:	City:	State:
Type of Dialysis: ☐ Hemodialysis – In Center ☐ Hemodialysis – At Home ☐ Peritoneal	Days of Hemodialysis: ☐ Monday – Wednesday – Friday ☐ Tuesday – Thursday - Saturday ☐ Everyday	Shift for Hemodialysis: ☐ Morning ☐ Afternoon ☐ Evening

Other Transplant Centers

Are you currently being evaluated or on the Wait List for a KIDNEY transplant at another center? ☐ No ☐ Yes – Please provide information		
Name of Center:	City:	State:

Previous Transplants

Have you ever had an organ transplant? ☐ No ☐ Yes – How many? _____			
#1	Organ type: ☐ Kidney ☐ Pancreas ☐ Liver Transplant Center:	Date transplanted:	Date failed:
#2	Organ type: Transplant Center:	Date transplanted:	Date failed:

MEDICARE Information

Do you have Medicare? ☐ No ☐ Yes - Please provide information

Medicare #:	Part D (Rx) – Prescription Drug Plan Name:

MEDICAID

Do you have Medicaid? ☐ No ☐ Yes - Please provide information

Medicaid I.D.#	Effective Date:

PRIVATE/COMMERCIAL Insurance

Do you have Private Insurance? ☐ No ☐ Yes - Please provide information

Primary Private Insurance

Insurance Company:	Policy or ID#
Insurer's Name:	Name of Employer:
Social Security Number:	Date of Birth:

☐ None

Secondary Private Insurance

Insurance Company:	Policy or ID#
Insurer's Name:	Name of Employer:
Social Security Number:	Date of Birth:

Personal Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Live-in partner ☐ Widowed	Years Married *or* Together:
Total Monthly Income: $	Total Monthly Expenses: (mortgage, cars, credit cards, loans, utilities) $
Are you *currently* attending school? ☐ No ☐ Yes	*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:

Employment Status

Are you working?

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

Emergency Contacts

Primary Contact		**Alternate Contact**	
Name:	**Relationship:**	**Name:**	**Relationship:**
Phone:		**Phone:**	

Health Habits and Personal Safety

Problems with Learning:	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
Personal Safety:	Do you live alone?.....			☐Yes ☐No
Alcohol and Drug Use:	Do you currently use **alcohol**?	☐No ☐Yes	Date of last use: _____/_____	
	How many years have you used / did you use?	Yrs:	Type:	
	Do you currently use **tobacco**?	☐No ☐Yes	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	☐No ☐Yes	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

Height:	_____ feet _____ inches	**Weight:**	_____ lbs
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 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:			
	Where were you immunized?: ☐ United States ☐ Mexico ☐ Other:			
	Have you had any recent vaccinations?.....	☐ Yes ☐No		
	If yes, state 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*

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:	
	Who is your Neurologist (Brain doctor)?	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:	
	Who is your Cardiologist (Heart doctor)?	Dr. _____

Personal Health Information

Pulmonary (Lungs)	Sleep Apnea	☐ Yes ☐No
	COPD	☐ Yes ☐No
	Tuberculosis /TB	☐ 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:	
	Who is your Pulmonologist (Lung doctor)?	Dr. _____
Endocrinology (Diabetes or Thyroid)	**Are you diabetic?** ☐No ☐ Yes – When	If yes, what type: ☐ I ☐ II
	When were you diagnosed with diabetes?	Age: _____ or Year:_____
	Have you had complications from diabetes?	☐ Retinopathy ☐Amputations
	Does anyone in your family have diabetes?	☐ Yes ☐No
	If yes, please list the relationship:	
	Do you have thyroid problems?	☐ Yes ☐No
	Comments:	
	Who is your Endocrinologist (**Diabetes**/Thyroid doctor)?	Dr. _____
Gastroenterology (Abdomen/ Intestines/ Liver/ Stomach)	History of Hepatitis A, B, or C	☐No ☐ Yes – Which one? ☐ 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:	
	Who is your Gastroenterologist (Abdomen/Stomach/Liver doctor)?	Dr. _____

Personal Health Information

Urology (Kidney/ Bladder/ Ureter/ Uretha)	Frequent bladder infections	☐No ☐ Yes
	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	☐No ☐ Yes
	History of kidney stones	☐ Yes ☐No
	History of enlarged prostate	☐ Yes ☐No
	History of bladder surgeries	☐ Yes ☐No
	Who is your Urologist (Kidney/Bladder/Ureter/Uretha)?	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?	☐No ☐ Yes: Type - _____
	Treatment: ☐ Radiation ☐ Chemotherapy - Date of last treatment: _____	
	Who is your Hematologist/Oncologist/Rheumatologist?	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?	☐No ☐ Yes – When:_____
	Who is your Psychiatrist or Psychologist?	Dr. _____

FEMALES ONLY		
Gynecology	Have you had a hysterectomy?	☐No ☐ Yes – 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
	Who is your Gynecologist?	Dr. _____
	If you have been pregnant, answer the following questions:	
	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:

Potential Living Donors

Are any family members or friends interested in becoming a living donor for you? ☐ **No** ☐ **Yes – please provide information**		
Provide their names -		
First Name:	**Last Name:**	**Relationship:**
First Name:	**Last Name:**	**Relationship:**

NOTE: National Living Donor Assistance Center (NLDAC)

The NLDAC is a foundation that will help pay for transportation and hotel costs for donors that live more than 60 miles outside of El Paso for individuals that qualify. Please consider asking family and friends that live Out-of-Town to be living donors.

Financial Consent

I request that Las Palmas Medical Center – Transplant Services begin the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start this process. I authorize my physicians to release my medical records to Las Palmas Medical Center – Transplant Services.

I authorize Las Palmas Medical Center – Transplant Services to release any medical information pertaining to my diagnosis and/or treatment, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment, or any other such related information to: 1) Representatives of local, state or federal agencies in accordance with law; 2) Medicare; 3) Medicaid; 4) my insurance company or it's designated representatives; 5) any person(s) or entities financially responsible for my care or treatment; 6) employees and representatives of Las Palmas Medical Center and or 7) individuals or entities for quality improvement, educational, medical research, accreditation or other purposes customarily utilized by hospitals and medical staffs in carrying out their functions.

The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred at Las Palmas Medical Center. I further authorize release of this information to health care providers associated with my care outside Las Palmas Medical Center to facilitate further health care.

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

TRANSPLANT SERVICES USE ONLY		
Date:	**Time:**	**Signature:**

RECIPIENT

Authorization for Release of Protected Health Information (PHI)

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:**