Kidney Transplant Referral Form

Dallas and Longview:
Baylor University Medical Center
Abdominal Transplant Program
Attn: Pre-transplant Department
3410 Worth St., Suite 950
Dallas, Texas 75246
PH: 214.820.2050 FAX: 214.820.6213

Fort Worth, Lubbock, and Amarillo:
Baylor Scott & White All Saints Medical Center – Fort Worth
Abdominal Transplant Program
Attn: Pre-transplant Department
1400 8th Ave., Fort Worth, Texas 76104
PH: 817.922.4650 FAX: 817.922.2310

Submit completed REFERRAL FORM and the following DOCUMENTS:

- ☐ Copy of Government Issued I.D. *(such as Driver's License)*
- ☐ Copy of Residency card *(if not US citizen)*
- ☐ Copy of Insurance Card(s) – *front and back*
- ☐ If on Dialysis- Copy of HCFA 2728 Form
- ☐ If not on Dialysis- eGFR or 24-hour Creatinine Clearance
- ☐ Recent labs and H&P- *recommended but not required*

TRANSPLANT REFERRAL				
Transplant Referral for: ☐ Kidney ☐ Kidney/Pancreas ☐ Pancreas Only				
Requested location for evaluation testing: ☐ Dallas ☐ Longview ☐ Fort Worth ☐ Lubbock ☐ Amarillo				
PATIENT INFORMATION				
Printed Name:		Social Security #:		
Date of Birth:	Age:	Sex: ☐ Male ☐ Female		
Address: Apt #:		City:	State:	ZIP:
Phone:	Cell:	Email:		
Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/Eskimo/ALEU ☐ Hawaiian Native Pacific Islander ☐ Other				
Ethnicity: ☐ Hispanic Origin ☐ Not of Hispanic Origin		U.S. Citizen: ☐ Yes ☐ No	US Resident: ☐ Yes ☐ No	
Do you speak English? ☐ Yes ☐ No	Language Preference:			
Insurance premiums are paid by: ☐ Self ☐ Employer ☐ Dialysis Center ☐ American Kidney Fund ☐ Other				
HEALTHCARE TEAM				
Referring provider name:			Phone:	
Address:	City:	State:	ZIP:	
Primary Care Doctor name			Phone	
Address:	City:	State:	ZIP:	
Dialysis Center:			Phone:	☐ Not on dialysis
Address:	City:	State:	ZIP:	
Type of Dialysis: ☐ Hemodialysis ☐ Peritoneal ☐ Home Hemodialysis		Dialysis Days: ☐ M/W/F ☐ TU/TH/SAT		
Person submitting referral (name):	Phone:	Email:		

HEALTH INFORMATION	
Height _____ Weight _____	What caused your kidney failure? _____ ☐ Yes ☐ No Do you permanently live in a Nursing Home? ☐ Yes ☐ No Are you currently being treated for cancer with chemotherapy? ☐ Yes ☐ No Do you currently have open wounds? ☐ Yes ☐ No Have you abused illegal substances within the last 3 months (excluding marijuana)?
Smoking History:	☐ Never ☐ Current: Packs per day _____ ☐ Previous: Year quit _____ # years smoked _____
Recreational Drugs:	☐ Never ☐ Yes: Last use _____ Type(s) _____
Transplant History:	On waitlist at another transplant center? ☐ Yes ☐ No

Transplant center:	Transplant coordinator:		Phone:
Previous transplant ☐ Yes ☐ No	Type:	When:	Where:
Medication Allergies:			

MEDICATIONS: List the names only *(dose and frequency not needed)*		

CANCER SCREENINGS: Type	When	Where:
Pap Smear		
Mammogram		
Colonoscopy		

PULMONARY (Lungs)

- ☐ TB/Tuberculosis
- ☐ History of positive TB Skin Test
  If yes, when were you treated? _____
- ☐ History of abnormal chest X-ray
- ☐ Chronic Bronchitis
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Oxygen Use
- ☐ Sleep Apnea
- ☐ CPAP Use
- ☐ History of lung masses/nodules
- ☐ History of lung cancer

Any additional problems/surgeries/recent testing that you have had related to your lungs: _____
_____
_____

CARDIAC and VASCULAR
(Heart and circulation)

- ☐ Hypertension/High Blood Pressure
- ☐ Frequent Fluid Overload/Congestive Heart Failure
- ☐ Coronary Artery Disease/Heart Disease
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Poor Circulation
- ☐ Pain in Legs when walking
- ☐ Amputations
- ☐ Blood Clots/DVT

Any additional problems/surgeries/recent testing that you have had related to your heart or circulation:
_____
_____

Cardiologist: _____
Telephone number: _____
Vascular Surgeon: _____
Telephone number: _____

NEPHROLOGY/UROLOGY
(Kidney/bladder/ureter/urethra)

- ☐ Frequent Bladder Infections
- ☐ History of Kidney Infections
- ☐ Kidney Stones
- ☐ If Yes, when: _____
- ☐ Have you had one of your kidneys removed?
  ☐ Yes ☐ No
- ☐ If Yes, which kidney:
  ☐ RIGHT ☐ LEFT ☐ BOTH

Any additional problems/surgeries/recent testing that you have had related to your kidneys, bladder, ureters, and/or urethra:
_____
_____

Urologist: _____
Telephone number: _____

GASTROENTEROLOGY
(Abdomen/Intestines/liver/stomach)

- ☐ Liver disease
- ☐ History of Hepatitis B
- ☐ Received Hepatitis B Vaccine
- ☐ History of Hepatitis C
- ☐ Reflux/Heartburn
- ☐ Problems swallowing
- ☐ History of vomiting blood
- ☐ History of intestinal problems
- ☐ Stomach Ulcer
- ☐ History of Polyps
- ☐ History of Blood in Stools
- ☐ Diverticulosis

Have you ever had a colonoscopy?
☐ Yes ☐ No
When? _____
Why? _____
Have you ever had an upper endoscopy?
☐ Yes ☐ No
When? _____
Why? _____

Any additional problems/surgeries/ recent testing you have had related to your abdomen, intestines, liver, and/or stomach:
_____
_____

Gastroenterologist: _____
Telephone number: _____
Hepatologist (Liver doctor):
_____
Telephone number: _____

ENDOCRINOLOGY (Diabetes or thyroid)

- ☐ Type 1 Diabetes: Age at diagnosis _____
- ☐ Type 2 Diabetes: Age at diagnosis _____
- ☐ Thyroid nodule/masses
- ☐ Thyroid surgically removed

Hospitalizations related to your diabetes (please give the date/name of hospital/ and what problems(s) caused you to be hospitalized):
_____
_____

Endocrinologist: _____
Telephone number: _____

NEUROLOGY (Brain and spinal cord)

- ☐ Headaches
- ☐ Head injury
- ☐ Seizures
- ☐ Stroke
- ☐ Spinal Cord injury

Any additional problems/surgeries/recent testing that you have had related to your brain or spinal cord:
_____
_____

Neurologist: _____
Telephone number: _____

HEMTOLOGY/ONCOLOGY/RHEUMATOLOGY
(Blood, cancer, autoimmune disease)

- ☐ History of bleeding problems
- ☐ Hemophilia
- ☐ Sickle Cell disease
- ☐ Amyloidosis
- ☐ Systemic Lupus Erythematosus
- ☐ Vasculitis
- ☐ Goodpasture's Disease
- ☐ History of Cancer
  Type: _____
  Treatment done: _____
  _____
  When was cancer diagnosed:
  _____
  Date of last treatment: _____

Have you ever had a blood transfusion?
☐ Yes ☐ No

Any additional problems/surgeries/recent testing that you have had related to your heart or circulation:
_____
_____

Oncologist: _____
Telephone number: _____
Rheumatologist: _____
Telephone number: _____

GYNECOLOGY (Breasts/female organs)

- ☐ Have you had a hysterectomy (uterus surgically removed)
- ☐ Abnormal pap smear
- ☐ History of breast lumps or masses
- ☐ Abnormal mammogram
- ☐ History of breast Biopsy

Any additional problems/surgeries/ recent testing you have had related to your female organs:
_____
_____

Gynecologist: _____
Telephone number: _____

INFECTIOUS DISEASE (HIV)
Do you have Human Immunodeficiency Virus?
☐ Yes ☐ No
If yes, length of time on HIV treatment:
_____
Is your viral load undetectable?
☐ Yes ☐ No

Doctor for HIV treatment:
_____
Telephone number: _____

DERMATOLOGY (Skin)
Do you have any skin disorders?
☐ Yes ☐ No
If yes, what kind: _____

Dermatologist: _____
Telephone number: _____

Kidney Transplant Evaluation and Release of Information Consent

I request that Baylor Scott & White All Saints Medical Center Fort Worth (FW) and Baylor University Medical Center (BUMC), part of Baylor Scott & White Health, 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 FW and BUMC. I authorize FW and BUMC 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 the law; 2) Medicare; 3) Medicaid; 4) my insurance company or its designated representatives; 5) any person(s) or entities financially responsible for my care or treatment; 6) employees and/or representatives of FW and BUMC for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against FW and BUMC and/or any member of the medical and house staff at FW and BUMC; and/or 7) individuals or entities for quality improvement, educational medical research, accreditations 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 any medical expenses incurred at FW and BUMC. I further authorize release of this information to healthcare providers associated with my care outside FW and BUMC to facilitate further healthcare.

_____ _____

Patient name (printed) Date of birth

_____

Patient signature