Kidney Transplant Referral Form

Baylor University Medical Center- DALLAS

Baylor Scott & White
ANNETTE C. AND HAROLD C. SIMMONS TRANSPLANT INSTITUTE
BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS

Send referral form and documents to KidneyTxpReferralDallas@bswhealth.org or FAX: 214.820.6213 PH: 214.820.2050

- ☐ Copy of Driver's License (or Government ID)
- ☐ 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
- ☐ Recent labs and H&P- *recommended*

TRANSPLANT REFERRAL

Transplant Referral for: ☐ Kidney ☐ Kidney/Pancreas ☐ Pancreas Only

PATIENT INFORMATION

Printed Name:		Date of Birth:	Age:
Address:	City	State:	Zip:
Cell phone:	Alternate phone:	Sex: ☐ Male ☐ Female	
Social Security #:	Email:		
Race: ☐ White ☐ Asian ☐ Hawaiian Native Pacific Islander ☐ Black ☐ Other ☐ American Indian/Eskimo/ALEU		Ethnicity: ☐ Hispanic Origin ☐ Not of Hispanic Origin	
U.S. Citizen: ☐ Yes ☐ No If No, specify:		Do you speak English? ☐ Yes ☐ No If No, what is preferred language:	
Insurance premiums are paid by: ☐ Self ☐ Employer ☐ Dialysis Center ☐ American Kidney Fund ☐ Other			

HEALTHCARE TEAM

Referring provider 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

Weight:	Height:	What caused your kidney failure?	
Nicotine History:	☐ Never ☐ Current- Type using:	☐ Previous- Year quit:	
Recreational Drugs:	☐ Never ☐ Current- Type using:	☐ Previous- Type used:	Last use:

TRANSPLANT HISTORY

On waitlist at another transplant center? ☐ Yes ☐ No		Transplant center name:	
Transplant coordinator name:		Transplant coordinator phone:	
Previous transplant ☐ Yes ☐ No	Organ:	Date:	Where:

CANCER SCREENINGS:

Type	When	Where
Pap Smear		
Mammogram		
Colonoscopy		

HEALTH HISTORY
Please check all that apply

PULMONARY (Lungs)
- ☐ TB/Tuberculosis
- ☐ Positive TB Test
  Treatment date: _____
- ☐ Emphysema/COPD
- ☐ Oxygen Use
- ☐ Sleep Apnea
- ☐ CPAP Use
- ☐ History of lung masses/nodules
- ☐ History of lung cancer

CARDIAC (Heart)
- ☐ Hypertension/High Blood Pressure
- ☐ Fluid Overload/Congestive Heart Failure
- ☐ Coronary Artery Disease/Heart Disease
- ☐ Heart Attack
- ☐ Heart Surgery

Cardiologist:
Name: _____
Phone: _____

NEPHROLOGY/UROLOGY (Kidney/bladder)
- ☐ Frequent Bladder Infections
- ☐ History of Kidney Infections
- ☐ Kidney Stones- year(s)_____
- ☐ Surgical removal of kidney
  ☐ RIGHT ☐ LEFT ☐ BOTH

Urologist
Name:_____
Phone: _____

ENDOCRINOLOGY (Diabetes or thyroid)
- ☐ Type 1 Diabetes:
  Age diagnosed _____
- ☐ Type 2 Diabetes:
  Age diagnosed _____
- ☐ Thyroid nodule/masses
- ☐ Thyroid surgically removed

VASCULAR (circulation)
- ☐ Poor Circulation
- ☐ Pain in Legs when walking
- ☐ Amputations
- ☐ Blood Clots/DVT

Vascular Surgeon:
Name:_____
Phone: _____

INFECTIOUS DISEASE (HIV)
- ☐ Human Immunodeficiency Virus

Year started treatment:_____
Is your viral load undetectable?
☐ Yes ☐ No

Doctor for HIV treatment:
Name:_____
Phone: _____

HEMATOLOGY/ONCOLOGY (Blood, cancer)
- ☐ History of bleeding problems
- ☐ Hemophilia
- ☐ Blood transfusion
- ☐ Sickle Cell disease
- ☐ Amyloidosis

- ☐ History of Cancer

Type: _____
_____
Year diagnosed:_____
Treatment type:_____
_____
Date of last treatment:_____

Oncologist:
Name:_____
Phone: _____

GYNECOLOGY (Breasts/female organs)
- ☐ Hysterectomy (uterus removed)
- ☐ Abnormal pap smear
- ☐ History of breast lumps or masses
- ☐ Abnormal mammogram
- ☐ History of breast Biopsy
- ☐ Other problems/testing related to female organs.
  List: _____

Gynecologist:
Name:_____
Phone: _____

GASTROENTEROLOGY (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

Gastroenterologist:
Name:_____
Phone: _____

DERMATOLOGY (Skin)
- ☐ Skin disorders

What type:_____
_____

Dermatologist:
Name:_____
Phone: _____

NEUROLOGY (Brain and spinal cord)
- ☐ Headaches
- ☐ Head injury
- ☐ Seizures
- ☐ Stroke
- ☐ Spinal Cord injury

Neurologist:
Name:_____
Phone: _____

RHEUMATOLOGY (autoimmune disease)
- ☐ Systemic Lupus Erythematosus
- ☐ Vasculitis
- ☐ Goodpasture's Disease

Rheumatologist:
Name:_____
Phone: _____

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Consent for Kidney Transplant Evaluation and Release of Information

I request that 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 BUMC. I authorize 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 BUMC for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against BUMC and/or any member of the medical and house staff at 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 BUMC. I further authorize release of this information to healthcare providers associated with my care outside BUMC to facilitate further healthcare.

_____	_____
Patient name (printed)	**Date of birth**
_____	_____
Patient Signature	**Date**

Baylor Scott and White Health Permission for Verbal Communication

I permit Baylor Scott & White Health to discuss my personal medical health information, in person and/or by telephone, with the following persons involved in my medical care for the following purposes:

- To orally schedule or confirm my appointments.
- To discuss my care including the results of diagnostic tests, diagnosis, prognosis, and treatment plans that may include mental health records, psychotherapy notes, AIDS/HIV test results, substance abuse treatment records, blood bank records, and/or genetic information; or
- To discuss billing and payment for medical services.

I understand that this document applies to all departments, healthcare providers and/or employees with Baylor Scott & White Health. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

Patient Contact(s) Name	Phone Number	Relationship	Role
			Verbal Communication
			Verbal Communication

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to Baylor Scott & White Health – Office of Corporate Compliance, 2401 S. 31st Street, MS-AR-300, Temple, Texas 76508. This document of permission for verbal communication is valid until revoked by the patient or patient's representative. This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at Baylor Scott & White Health.

_____	_____
Patient name (printed)	**Date of birth**
_____	_____
Patient Signature	**Date**