

# UT Southwestern Medical Center

## UT Southwestern Kidney Transplantation Application and Recipient History

5939 Harry Hines Blvd.  
Professional Office Building 2, Suite 700  
Dallas, TX 75390-9258  
Clinic – 214-645-1919  
Fax – 214-645-1901

UT Southwestern Medical Record #: \_\_\_\_\_

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

SSN: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Are you a US Citizen?  Yes  No If No, what country? \_\_\_\_\_

Are you a legal resident?  Yes  No What is your primary language? \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State Issued: \_\_\_\_\_

Allergies (Please include reactions): \_\_\_\_\_

WEIGHT: \_\_\_\_\_ lbs. HEIGHT: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dialysis Center: \_\_\_\_\_ Phone: \_\_\_\_\_

What is your preferred UT Southwestern location?  Dallas  Lubbock  Tyler

Do you have any potential living donors?  Yes  No If Yes, please let us know if, and how, we can provide a living donor application to them.

### INSURANCE INFORMATION

Primary Insurance Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's D.O.B.: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Eligibility Date: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's D.O.B.: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Eligibility Date: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Disclosure of your Social Security Number (SSN) is requested from you in order for UT Southwestern to facilitate positive patient identification. No statute or other authority requires that you disclose your SSN for that purpose. Failure to provide your SSN, however, may result in a lack of positive patient identification. Further disclosures of your SSN are governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.



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**NEPHROLOGY (KIDNEY)**

Name of Nephrologist: \_\_\_\_\_ Phone number: \_\_\_\_\_

Type of Dialysis:  Hemodialysis  Peritoneal Dialysis  Home Hemodialysis  Not yet on dialysis

Dialysis Days:  M/W/F  T/Th/Sat Dialysis Shift:  1st  2nd  3rd

Date of first dialysis treatment: \_\_\_\_\_

Have you been evaluated for transplant at another transplant center?  Yes  No

Are you currently on a transplant waitlist?  Yes  No

If Yes, name of transplant center: \_\_\_\_\_ Phone number: \_\_\_\_\_

Have you received a transplant previously?  Yes  No Location / Date: \_\_\_\_\_

Have you ever had a Kidney Biopsy?  Yes  No Location / Date: \_\_\_\_\_

Have you had significant weight change (increase or decrease) in the last two years?  Yes  No

List any additional problems/surgeries/recent testing you have had related to your kidneys: \_\_\_\_\_

**GENERAL MEDICAL INFORMATION**

Name of Primary Care Physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Have you been hospitalized in the last two years?  Yes  No Date of Admission: \_\_\_\_\_

Name and location of hospital: \_\_\_\_\_

Have you had any surgeries not already listed?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you ever had a colonoscopy?  Yes  No

Name and location of colonoscopy: \_\_\_\_\_

Do you have diabetes?  Yes  No

If yes, for how many years? \_\_\_\_\_

Have you ever had an Echocardiogram?  Yes  No

Name and location of Cardiologist performing Echo: \_\_\_\_\_

For female patients, date of your last Pap Smear: \_\_\_\_\_ Mammogram: \_\_\_\_\_

Name of Gynecologist: \_\_\_\_\_ Phone number: \_\_\_\_\_

Do you see any other physicians on a routine basis?

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

