

**FLORIDA HOSPITAL TRANSPLANT CENTER**  
**KIDNEY TRANSPLANT RECIPIENT APPLICATION**

This application **MUST** be filled out completely.  
ALL incomplete applications will be returned to sender

**Name** \_\_\_\_\_  
(First) (MI) (Last) (Maiden)

**Address** \_\_\_\_\_  
(Street) (Apt.)  
\_\_\_\_\_  
(City) (State) (Zip) (County)

**Phone**  
**Home**(\_\_\_\_\_) **Work** (\_\_\_\_\_) **Cell** (\_\_\_\_\_) \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Sex: M/F**

**Employer:**(Full time/Part time) \_\_\_\_\_ **Phone** \_\_\_\_\_

**Marital Status:** Single / Married / Divorced / Widowed / Separated (Circle One)

**Spouse/Significant Other: Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ (work)  
\*Is this person your first contact in case of emergency? Y/N \_\_\_\_\_ (cell)

**Other Emergency Contacts**

<b>Name:</b> _____	<b>Name:</b> _____
<b>Phone: (H)</b> _____	<b>Phone: (H)</b> _____
<b>(cell/work)</b> _____	<b>(cell/work)</b> _____
<b>Relationship:</b> _____	<b>Relationship:</b> _____

**Education completed:** (check one) **Grade school** \_\_\_ **College: 2 years** \_\_\_  
**High school** \_\_\_ **College: 4 years** \_\_\_ **College: > 4 years** \_\_\_

**Race:** \_\_\_\_\_ **Hispanic Origin?** Y/N **U.S. Citizen?** Y/N - if no, number of years in U.S. \_\_\_  
**Primary language spoken:** English / Spanish / Other \_\_\_\_\_  
**Can you read English?** Y/N **Can you understand spoken English?** Y/N

If primary language is not English, who can we contact on your behalf that speaks English?

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

If you do not understand English, you will need to bring an interpreter to ALL appointments.

**Primary Care Doctor** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Kidney Doctor** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Heart Doctor** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Height** \_\_\_\_\_ **Wt** \_\_\_\_\_ (lbs) **Visual Impairment:** Y/N **Hearing Impairment:** Y/N

**Allergies:** \_\_\_\_\_

<p><u>For Office Use Only:</u> Medical Record #: _____</p>
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**MEDICAL HISTORY**

*(Please circle)*

Diabetes **No/Yes** Age when you found out you were diabetic: \_\_\_\_\_  
 Do you take insulin? **No/Yes**  
 Do you take pills for diabetes? **No/Yes**  
 High Blood Pressure **No/Yes**  
 Heart Disease **No/Yes**  
 Tuberculosis **No/Yes**  
 Stomach Ulcer **No/Yes**  
 Seizures **No/Yes** Cause of seizure \_\_\_\_\_ Treatment \_\_\_\_\_  
 Hepatitis A **No/Yes**  
 Hepatitis B **No/Yes** Have you received treatment for Hepatitis B or C? Y/N  
 Hepatitis C **No/Yes** Have you had a liver biopsy done for Hepatitis B or C? Y/N  
 Doctor who treated you for Hepatitis: \_\_\_\_\_

Blood Transfusions **No/Yes** How many? \_\_\_\_\_ Date of last transfusion \_\_\_\_\_  
 Would you be willing to receive blood if needed? YES \_\_\_ NO \_\_\_

Cancer **No/Yes** When: \_\_\_\_\_  
 Type of Cancer: \_\_\_\_\_  
 Treatment \_\_\_\_\_  
 Doctor who treated cancer \_\_\_\_\_

\*\*\*PATHOLOGY REPORTS FROM ALL CANCERS MUST BE INCLUDED WITH APPLICATION\*\*\*\*

**Surgeries:** (Please list any surgeries you have had with the approximate dates)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you smoke? Y/N Did you ever smoke? Y/N How long? \_\_\_\_\_ Date quit: \_\_\_\_\_  
 Have you ever used recreational drugs? Y/N Do you currently use recreational drugs? Y/N  
 Name of recreational drugs used: \_\_\_\_\_  
 Do you drink alcohol? Y/N If yes, how often? \_\_\_\_\_  
 Are you seeing a mental health specialist? Y/N  
 Are you taking medication for anxiety and/or depression? Y/N  
 Name of medications: \_\_\_\_\_

**For Females:** Number of pregnancies: \_\_\_\_\_ Is it still possible for you to become pregnant? Y/N  
 Type of birth control being used: \_\_\_\_\_

**Kidney Disease History**

What caused your kidneys to fail? \_\_\_\_\_

Have you started dialysis yet? Y/N If yes, circle one: Hemodialysis CAPD CCPD

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

Name of current Dialysis Center: \_\_\_\_\_ Phone: \_\_\_\_\_

Dialysis schedule: (circle one) **MWF TTS** Shift: (circle one) **1<sup>st</sup> 2<sup>nd</sup> 3rd** Nocturnal at center  
Home Hemodialysis

**Transplant History**

Have you had a previous kidney transplant? (Please circle) **Yes No**

If YES, please complete the following information:

Transplant Center \_\_\_\_\_ Date of Transplant: \_\_\_\_\_

Transplant Doctor \_\_\_\_\_ Rejection Date: \_\_\_\_\_

Donation source? (Please circle) **Living Donor** Name of Living Donor: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**Deceased Donor**

Which side is kidney on? (Please circle) **Left Right** Is the kidney still in place? **Yes No**

Other organ transplants/dates \_\_\_\_\_

**APPLICATION CHECKLIST**

Please read complete list. The following records **MUST** be returned with the application:

- \_\_\_ Nephrologist's History and physical- typed copy
- \_\_\_ Current office notes/progress notes from nephrologist
- \_\_\_ Dialysis Social Worker Initial Evaluation-(only if patient has started dialysis already)
- \_\_\_ Copy of ESRD Form 2728 (for patients on dialysis-dialysis center will have copy)
- \_\_\_ Recent labs from dialysis center or nephrologist's office
- \_\_\_ Copies of Driver's License, Insurance cards and drug coverage cards: front and back
- \_\_\_ Completed Insurance Information sheet (page 4)
- \_\_\_ Pathology reports and treatment records for any patient with a history of cancer
- \_\_\_ Colonoscopy results **ALL patients 50 yrs and older**
- \_\_\_ Pap Smear results **ALL female patients 18 yrs and older**
- \_\_\_ Mammogram results **ALL female patients 40 yrs and older**
- \_\_\_ **\*\*Nuclear Stress test results within the last 12 months**
- \_\_\_ **\*\*Written Cardiac clearance for transplant surgery**  
**\*\* All diabetics and patients 50 yrs and older**

I have completed the application and enclosed all necessary reports on the checklist. I understand that laboratory/diagnostic testing and psychosocial evaluation will be done during my kidney transplant evaluation.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of person who assisted you with completing this application: \_\_\_\_\_

Return completed application to: **Florida Hospital Transplant Center  
2415 N. Orange Ave, Suite 700  
Orlando, FL 32804  
Fax 407-303-2998**

## Insurance Information

Include copies of Insurance cards and Drug cards-front and back.

Patient Name: \_\_\_\_\_ Social Security# \_\_\_\_\_

### MEDICARE INFORMATION

Medicare Number \_\_\_\_\_ Primary Secondary Third Pending  
Part A Effective Date: \_\_\_\_\_ (Circle one)  
Part B Effective Date: \_\_\_\_\_  
Date Medicare became Primary: \_\_\_\_\_  
If not currently on Medicare, are you Medicare eligible? Y/N

### MEDICAID INFORMATION

Medicaid Number \_\_\_\_\_ (Circle one) Primary Secondary Third Pending  
Medically Needy: Y/N If yes, Share of Cost Amount \_\_\_\_\_

### OTHER INSURANCE

(Circle one) Primary Secondary Third Pending  
Insurance company name: \_\_\_\_\_ Phone: \_\_\_\_\_  
ID Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Type (Circle One) HMO PPO POS Indemnity Other \_\_\_\_\_  
Employer/Group Name \_\_\_\_\_  
Insured's Name (if other than patient) \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insured's Social Security Number \_\_\_\_\_ Insured's DOB \_\_\_\_\_  
Primary Care MD \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Is this a COBRA policy? Y/N Effective date: \_\_\_\_\_ Termination date \_\_\_\_\_  
Insurance Premiums are paid by: \_\_\_\_\_

### OTHER INSURANCE

(Circle one) Primary Secondary Third Pending  
Insurance company name: \_\_\_\_\_ Phone: \_\_\_\_\_  
ID Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Type (Circle One) HMO PPO POS Indemnity Other \_\_\_\_\_  
Employer/Group Name \_\_\_\_\_  
Insured's Name (if other than patient) \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insured's Social Security Number \_\_\_\_\_ Insured's DOB \_\_\_\_\_  
Primary Care MD \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Is this a COBRA policy? Y/N Effective date: \_\_\_\_\_ Termination date \_\_\_\_\_  
Insurance Premiums are paid by: \_\_\_\_\_

### PRESCRIPTION DRUG COVERAGE

My prescription drug coverage is through:

\_\_\_\_ Medicare Part D: \_\_\_\_\_ (Name of Company) Phone# \_\_\_\_\_ ID# \_\_\_\_\_  
\_\_\_\_ Private Insurance: \_\_\_\_\_ (Name of Company) Phone# \_\_\_\_\_ ID# \_\_\_\_\_  
\_\_\_\_ Medicaid  
\_\_\_\_ VA Location \_\_\_\_\_ Phone \_\_\_\_\_

Retail/Brand name co-pay \$ \_\_\_\_\_ Generic co-pay \$ \_\_\_\_\_ Mail order\$ \_\_\_\_\_ Maximum benefit \$ \_\_\_\_\_

## Florida Hospital Transplant Center Financial Agreement

Organ transplantation is an expensive undertaking that requires a serious commitment. It represents a partnership between you, your physicians, and the transplant team. How you are going to pay for the transplant and necessary on-going care and medications should not be an additional burden that you should be facing.

Therefore, it is important for you to understand the terms and conditions of your current insurance and keep apprized of any changes that may occur with your insurance coverage. Initially, our Financial Coordinator will verify your insurance benefits and determine coverage for transplant here at Florida Hospital. She will periodically contact you and/or your insurance company to determine any changes in coverage. However, it remains YOUR RESPONSIBILITY to be aware of any changes to your insurance coverage and to notify our Financial Coordinator of those changes, in writing, within one week of the change. A copy of the new insurance card must be sent to us, along with a legible phone number so that we may contact your new insurer to verify transplant benefits at our facility. Failure to do this may jeopardize your ability to receive a kidney transplant at Florida Hospital.

If you elect to change coverage, it is important to ensure that you select an insurance company that will cover your transplant at Florida Hospital, your follow-up care and subsequent medication needs. Ultimately, YOU are financially responsible for the medical services you receive. If your insurance company does not cover transplant services here, or if there is a co-pay or deductible, which is not covered by Medicare or your group plan, then you will be financially responsible for these payments. Accordingly, it is pivotal for you to maintain uninterrupted insurance coverage and ensure that your new insurance will reimburse your care adequately and underwrite the cost of your ongoing medical needs.

Our Financial Coordinator can advise you on which insurance plans provide adequate coverage, as well as explain Medicare regulations as they pertain to End Stage Renal Disease. Our Social Worker can advise you on state Medicaid regulations and eligibility requirements. We STRONGLY advise transplant patients to opt for **Medicare Part B**, as well as Part A once their Medicare eligibility begins. (Please note: If a potential living donor is being considered, it is imperative to have Medicare Part B.)

If you have any questions or concerns regarding the financial aspects of your kidney transplant, please contact the Transplant Financial Coordinator, at 407-644-3770 ext. 261.

Please sign and date the agreement below and return it to Florida Hospital Transplant Center along with the rest of your application packet. Thank you.  
You may wish to make a copy of this for your records.

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### AGREEMENT:

I understand that financial approval is based on my current insurance benefits and eligibility. If any changes occur to my insurance coverage, I agree to notify Florida Hospital Transplant Center within one week of the change. My failure to do so can result in an insurance denial and/or my personal liability for any and all charges associated with the procedure. My signature below authorizes Florida Hospital Transplant Center to release information for purposes of obtaining approval for my transplant.

I understand and accept the terms of this financial agreement.

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PRINT NAME

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DATE OF BIRTH

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PATIENT'S SIGNATURE

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DATE