

FLORIDA HOSPITAL TRANSPLANT CENTER
LIVER 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: _____ 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

Name: _____ Name: _____ Phone: _____
(H) _____ Phone: (H) _____
(cell/work) _____ (cell/work) _____
Relationship: _____ Relationship: _____

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 at Translife*

Primary Care Doctor _____ Phone _____ Liver

Doctor _____ Phone _____ Heart

Doctor _____ Phone _____

Height _____ Wt _____ (lbs) Visual Impairment: Y/N Hearing Impairment: Y/N

Allergies: _____

MEDICAL HISTORY

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 _____

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 Do you

smoke? Y/N Did you ever smoke? Y/N How long? ____ Date quit: _____ For Females:

Number of pregnancies: ____ Is it still possible for you to become pregnant? Y/N Type of birth

control being used: _____ Liver Disease History Diagnosis

of liver failure: _____ When did you

find out you had liver failure? _____ Do you drink

alcohol? _____ How much? _____ per day / week {please circle} Are you currently

involved in AA? _____ May we contact your sponsor? _____ Where do you attend

meetings? _____ How often do you go to meetings? _____ Do you currently use

recreational or prescription narcotics? _____ Drugs you are currently

using: _____ Did you ever use

recreational drugs? _____ Drugs used: _____ Are you currently

involved in NA? _____ May we contact your sponsor? _____ Where do you attend

meetings? _____ How often do you go to meetings? _____ Have you or are you

currently seeing a counselor for substance abuse? _____ If so, who are you

seeing? _____ May we contact them? Yes/ No If yes, please be sure to fill

out the release of information form that is attached.

Have you received vaccinations for Hepatitis A? Yes/ No If Yes, When? _____

Have you received vaccinations for Hepatitis B? Yes/ No If Yes, When? _____

Have you ever been told you have Hepatitis A? Yes/ No If Yes, When? _____

Name of doctor who treated you: _____ Phone number: _____

Have you ever been told you have Hepatitis B? Yes/ No If Yes, When? _____

Name of doctor who treated you: _____ Phone number: _____

Have you ever been told you have Hepatitis C? Yes/ No If Yes, When? _____

Name of doctor who treated you: _____ Phone number: _____

History of: Please check Yes No

Encephalopathy? _____ If yes, Grade: _____ Ascites? _____

_____ Date of last paracentesis: _____

_____ Frequency: _____ TIPS? _____
_____ Date: _____ GI Bleed? _____ Date: _____

_____ Hepatorenal Syndrome? _____ Hepatopulm. _____

Syndrome? _____ SPB? _____ Currently hospitalized? _____ Name of
Hospital: _____

Recent laboratory values: Date: _____ INR: _____ Creatinine: _____ Albumin: _____

Current MELD score: _____ Date: _____

If you have ever had a liver biopsy done, please obtain the results and return it along with your application. This will prevent delay in your evaluation process.

Past surgical history: Please give approximate dates of surgery and type of surgery done.

Transplant History

Have you had a previous organ transplant? Y/N What type? _____ If

yes, complete the following information: Transplant Center _____ Date of

Transplant _____ Transplant Doctor _____ Living Donor

Deceased Donor *If living, Name of Donor: _____

(circle one) Relationship: _____

APPLICATION
CHECKLIST

If the application is incomplete, it will be returned to the sender. The following information MUST be included in order for the application to be complete:

- ___ History and physical- typed copy from Hepatologist or gastroenterologist
- ___ Current office notes/progress notes from Hepatologist or gastroenterologist
- ___ Recent labs from Hepatologist or gastroenterologist
- ___ Copies of Insurance cards and drug coverage cards: front and back
- ___ Completed Insurance Information sheet (page 4)
- ___ Pathology reports for any patient with a history of cancer
- ___ Pathology reports for any liver biopsy
- ___ Results of viral loads of Hepatitis B and or Hepatitis C

For ALL diabetic patients and ALL patients > 50 yrs old

- ___ Nuclear Stress test results within the last 12 months
- ___ Written Cardiac clearance for transplant surgery

The following tests will need to be scheduled by the patient with their private physicians, *but reports are not required in order to begin processing application:*

- ___ **ALL patients \geq 50 yrs:** Colonoscopy is required every 5 years. Send report if available.
- ___ **Females:** Pap Smear and Mammogram need to be done annually. Send report if available.

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

Patient

Signature _____ **Date** _____

Name of person who assisted you with completing this application: _____

Return application to:
Florida Hospital Transplant Center
2415 N. Orange Ave, Suite #700
Orlando, FL 32804

**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

(Circle one) **Medicaid**

Number _____ 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 \$ _____