FLORIDA HOSPITAL TRANSPLANT CENTER

CLINIC DEMOGRAPHIC INFORMATION

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 Home _____**Work** _____**Cell** _____
***Is this person your first contact in case of emergency? Y / N**

Other Emergency Contacts

Name _____
Phone Home _____
Work _____
Cell _____
Relationship _____

Name _____
Phone Home _____
Work _____
Cell _____
Relationship _____

Height_____ **Weight**_____ **Visual Impairment: Y / N Hearing Impairment: Y / N**
Allergies:_____

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** _____

<u>If you do not understand English, you will need to bring an interpreter to ALL appointments</u>

Referring Doctor _____**NPI#**_____ **Phone**_____
Address _____ **Fax**_____
Heart Doctor_____**NPI#**_____ **Phone**_____
Address _____ **Fax**_____
Primary Care Doctor _____**NPI#**_____ **Phone**_____
Address _____ **Fax**_____

<u>For Office Use Only</u>:
Medical Record #: _____

MEDICAL HISTORY

Diabetes	**Y / N**	
Insulin	**Y / N**	
Diabetic Medication	**Y / N**	**Age when diagnosed with diabetes_____**
High Blood Pressure	**Y / N**	
Heart Disease	**Y / N**	
Tuberculosis	**Y / N**	
Stomach Ulcer	**Y / N**	
Seizures	**Y / N**	**Cause of seizure_____** **Treatment_____**
Hepatitis A	**Y / N**	
Hepatitis B	**Y / N**	
Hepatitis C	**Y / N**	**Have you received treatment for Hepatitis B or C? Y/N** **Have you had a liver biopsy done for Hepatitis B or C? Y/N** **Doctor who treated you for Hepatitis _____**
Blood Transfusions	**Y / N**	**How many? _____ Date of last transfusion _____** **Would you be willing to receive blood if needed? Y / N**
Cancer	**Y / N**	**When: _____** **Type of Cancer_____** **Treatment _____** **Doctor who treated Cancer_____**

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

Surgery: (Please list any surgeries you have had with the approximate dates**)**

Type of Surgery	Date of Surgery/Hospital
CABG	
Aortic Valve	
Mitral Valve	
ICD/Pacemaker (please list type)	
Stents	
Other:	
Other:	

Do you smoke? Y/N
Did you ever smoke? Y/N
If yes, 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
If yes, type of birth control being used_____

MEDICAL HISTORY

What caused your heart to fail? _____

Have you been told that your kidneys are not working because of the heart failure? Y/N

Current heart failure treatment _____

TRANSPLANT HISTORY

Have you had a previous organ transplant? Y/N
If yes, complete the following information:

Type of Transplant _____

Transplant Center _____

Date of Transplant _____

Transplant Doctor _____

Living Donor / Deceased Donor
(circle one)
***If living, Name of Donor:_____Relationship:_____**

APPLICATION CHECKLIST

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

___ Cardiologist's History and physical- typed copy
___ Current office notes/progress notes from Cardiologist's office
___ Recent labs from Cardiologist's office or Primary Office
___ Copies of 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
___ Cardiac catheterization results (if done)
____ Echocardiogram results
___ Chest x-ray and/or CAT scans (if done)

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 heart 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_____**SocialSecurity#**_____

MEDICARE INFORMATION

Medicare Number_____ **Primary / Secondary / Tertiary / 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_____ **Primary / Secondary / Tertiary / Pending**
(Circle one)
Medically Needy: Y/N If yes, Share of Cost Amount_____

OTHER INSURANCE

Primary / Secondary / Tertiary / Pending
(Circle one)
Insurance company name:_____ **Phone**_____
ID Policy #_____ **Group #**_____
Policy Type (Circle One) **HMO PPO POS Indemnity Other**_____
Employer / Group Name_____
Insured's Name _____ **Relationship to patient**_____
Insured's Social Security #_____ **Insured's Date of Birth**_____
Primary Care MD_____**Phone**_____**Fax**_____
Is this a COBRA policy? Y / N Effective date_____ **Termination date**_____
Insurance Premiums are paid by:_____

OTHER INSURANCE

Primary / Secondary / Tertiary / Pending
(Circle one)
Insurance company name:_____ **Phone:**_____
ID Policy #_____ **Group #**_____
Policy Type (Circle One) **HMO PPO POS Indemnity Other**_____
Employer / Group Name_____
Insured's Name _____ **Relationship to patient**_____
Insured's Social Security #_____ **Insured's Date of Birth**_____
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 apprised 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 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 Heart 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.

If you have any questions or concerns regarding the financial aspects of your heart transplant, please contact the Transplant Financial Coordinator, at 407 303-2474.

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.

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.

_____	_____
PRINT NAME	DATE OF BIRTH
_____	_____
PATIENT'S SIGNATURE	DATE