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 ≥ 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:_____**SocialSecurity#**_____

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 $**_____