



Baylor Scott & White

ANNETTE C. AND HAROLD C. SIMMONS
TRANSPLANT INSTITUTE

BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS
BAYLOR SCOTT & WHITE ALL SAINTS MEDICAL CENTER – FORT WORTH

KIDNEY TRANSPLANT APPLICATION

I would like to be considered for: Kidney Kidney/Pancreas Pancreas Only

I would like to have my evaluation testing in: Dallas Longview

Fort Worth Lubbock Amarillo

PATIENT INFORMATION		Name:			
Address:		Apt #:	City:	State:	Zip:
Social Security #:			Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Eskimo/ALEU <input type="checkbox"/> Hawaiian Native/Pacific Islander <input type="checkbox"/> Other					
Ethnicity: <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Not of Hispanic Origin					
Phone #:		Cell #:	E-mail:		
U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No		Language Preference:		Do you speak English: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact:				Phone #:	

MEDICARE/MEDICAID INFORMATION			(Please include a copy of all insurance cards)		
Medicare ID#:		Medicaid ID#:	Texas Kidney Health Plan #:		

INSURANCE INFORMATION			
Primary Policy Holder's Name:		Date of Birth:	Social Security #:
Insurance Company:		Customer Service #:	
Policy / ID #:		Group #:	

ADDITIONAL INFORMATION		Referring Physician:			
Address:		City:	State:	Zip:	
Phone #:		Fax #:			
Name of Dialysis Center:		Phone #:	City:		
Dialysis Center Social Worker:					
Type of Dialysis: <input type="checkbox"/> Not yet on dialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Home Hemodialysis				Height:	Weight:
Dialysis Days: <input type="checkbox"/> M/W/F <input type="checkbox"/> T/Th/Sat			Date of first dialysis:		
Previous Transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Transplant Center:		City:	Date:

PATIENT REQUEST TO BEGIN EVALUATION AND FINANCIAL CLEARANCE PROCESS	
<p>I request that Baylor Scott & White All Saints Medical Center – Fort Worth (FW) and Baylor University Medical Center, part of Baylor Scott & White (BUMC) begin the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start this process. I authorize my physicians to release my medical records to FW and BUMC. I authorize FW and BUMC to release any medical information pertaining to my diagnosis and/or treatment, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), laboratory test results, medical history, treatment, or any other such related information to: 1) Representatives of local, state or federal agencies in accordance with law; 2) Medicare; 3) Medicaid; 4) my insurance company or its designated representatives; 5) any person(s) or entities financially responsible for my care or treatment; 6) employees and/or representatives of FW and BUMC for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against FW and BUMC and/or any member of the medical and house staff at FW and BUMC; and/or 7) individuals or entities for quality improvement, educational, medical research, accreditations or other purposes customarily utilized by hospitals and medical staffs in carrying out their functions. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for any medical expenses incurred at FW and BUMC. I further authorize release of this information to healthcare providers associated with my care outside FW and BUMC to facilitate further healthcare.</p>	
Patient Signature:	Date:
Print Name:	

REQUIRED DOCUMENTS		(Please provide a copy of the following required documents)	
<input type="checkbox"/> Copy of Government Issued I.D. such as Drivers License or Passport <input type="checkbox"/> Copy of Insurance Card(s) – front and back <input type="checkbox"/> Recent History and Physical from Nephrologist (within past year) <input type="checkbox"/> Most Recent Height and Weight from Nephrologist or Dialysis Center	If on Dialysis:	<input type="checkbox"/> Recent History of Compliance <input type="checkbox"/> TB Test (within past year) <input type="checkbox"/> Copy of HCFA 2728 Form	
	If Not on Dialysis:	<input type="checkbox"/> eGFR or 24 Hour Creatinine Clearance	

Addresses for Baylor Scott & White
Annette C. and Harold C. Simmons
Transplant Institute applications are:

For Dallas and Longview:
Baylor University Medical Center
Abdominal Transplant Program
Attention: Pre-Transplant Department
3410 Worth Street, Suite 950, Dallas, TX 75246
PH: 214.820.2050 • Fax: 214.820.6213

For Fort Worth, Lubbock and Amarillo:
Baylor Scott & White All Saints Medical Center - Fort Worth
Attention: Pre-Transplant Department
1400 8th Avenue, Fort Worth, TX 76104
Ph: 817.922.4650 • Fax: 817.922.2310