Scott&White
MEDICAL CENTER
TEMPLE
Part of Baylor Scott & White Health

KIDNEY TRANSPLANT APPLICATION

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

I would like to have my evaluation testing in: □ Temple □ Round Rock □ Abilene

PATIENT INFORMATION	Name:		
Address: Apt #:	City: State: Zip:		
Social Security #:	Date of Birth:	Sex: □ Male □ Female	
Race: □ White □ Black □ Asian □ American Indian/Eskimo/ALEU □ Hawaiian Native/Pacific Islander □ Other			
Ethnicity: □ Hispanic Origin □ Not of Hispanic Origin			
Phone #: Cell #: E-mail:			
U.S. Citizen: □ Yes □ No	Language Preference:	Do you speak English: □ Yes □ 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: □ Not yet on dialysis □ Peritoneal □ Hemodialysis □ Home Hemodialysis		Height: Weight:
Dialysis Days: □ M/W/F □ T/Th/Sat	Date of first dialysis:	
Previous Transplant: □ Yes □ No	If Yes, Transplant Center: City: Date:	

PATIENT REQUEST TO BEGIN EVALUATION AND FINANCIAL CLEARANCE PROCESS

I request that Scott & White Medical Center – Temple begins 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 Scott & White Medical Center – Temple and Scott & White Clinics. I authorize Scott & White Medical Center – Temple and Scott & White Clinics 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 Scott & White Medical Center – Temple and Scott & White Clinics, for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against Scott & White Medical Center Temple and Scott & White Clinics and/or any member of the medical and house staff at Scott & White Medical Center and Scott & White Clinics; 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 Scott & White Medical Center and Scott & White Clinics. I further authorize release of this information to health care providers associated with my care outside Scott & White Medical Center and Scott & White Clinics to facilitate further health care.

Patient Signature: Date:

Print Name:

REQUIRED DOCUMENTS (Please provide a copy of the following required documents)

- □ Copy of Government Issued I.D. such as Drivers License or Passport
- □ Copy of Insurance Card(s) – front and back
- □ Recent History and Physical from Nephrologist (within past year)
- □ Most Recent Height and Weight from Nephrologist or Dialysis Center

If on Dialysis:
- □ Recent History of Compliance
- □ TB Test (within past year)
- □ Copy of HCFA 2728 Form

If Not on Dialysis:
- □ eGFR or 24 Hour Creatinine Clearance

Mailing Address for Scott & White Medical Center Transplant Services:

2401 S. 31st Street
Temple, TX 76508
Phone: 254.724.8912
Fax: 254.724.4153
Or email to transplant@sw.org

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