

## Methodist Dallas Medical Center Recipient Application for Organ Transplant

All pages must be filled out completely and signed in order to process your application.

If your application is incomplete, it will be returned to you, which will delay the processing of your request.

For assistance in filling out your application, please call 214-947-1800 or toll-free 1-800-284-2185.

Page 1 of 3

Application for (check all organs that apply):  Kidney  Pancreas  Liver/Kidney

Possible donor sources:  Living Related  Living Unrelated  Deceased Donor  Paired Donor Exchange

Who referred you to Methodist?  Physician  Insurance  Self  Other

### PHYSICIAN INFORMATION

Your Kidney or Liver Doctor: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Address: \_\_\_\_\_

Would you like us to contact your physician by telephone?  Yes  No

### PATIENT INFORMATION

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
                    LAST                      FIRST                      MIDDLE                      (MAIDEN)                      SOCIAL SECURITY #

Mailing Address: \_\_\_\_\_  
  STREET ADDRESS    APT. #

                    CITY    STATE    ZIP

Home Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Religion: \_\_\_\_\_ Race: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

Patient employed by: \_\_\_\_\_ Work phone: (     ) \_\_\_\_\_

Work Status:  Full-Time  Part-time  Retired  Disabled

Is patient a U.S. Citizen?  Yes  No If "no," what country? \_\_\_\_\_

Does patient speak English?  Yes  No If "no," what language? \_\_\_\_\_

### SPOUSE OR PARENT (IF MINOR) INFORMATION

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: (     ) \_\_\_\_\_

Alternate Contact Person:

Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**INSURANCE INFORMATION**

MEDICARE I.D.: \_\_\_\_\_ Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Medicare Due To (Check One):  Kidney Disease  Age

Social Security Disability: \_\_\_\_\_

MEDICARE I.D.: \_\_\_\_\_ Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*Texas Residents Only*

Texas Kidney Healthcare I.D.: \_\_\_\_\_

**INSURANCE COMPANY ONE**

HMO  PPO  POS  Indemnity Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Name of Group/Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Benefits Phone Number: ( ) \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# of Insured Person: \_\_\_\_\_

Other I.D. Number: \_\_\_\_\_

**INSURANCE COMPANY TWO**

HMO  PPO  POS  Indemnity Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Name of Group/Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Benefits Phone Number: ( ) \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# of Insured Person: \_\_\_\_\_

Other I.D. Number: \_\_\_\_\_

Are you currently listed at another Transplant Center?  Yes  No

Transplant Center: \_\_\_\_\_

Address: \_\_\_\_\_

CITY

STATE

ZIP

**DIALYSIS INFORMATION**

Primary Diagnosis (*example: diabetes, FSGS, hypertension*) \_\_\_\_\_

Currently on Dialysis?  Yes  No

Date Current Dialysis Began: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Type of Dialysis (Check One):  Home Hemo  PD  In-center Hemo \_\_\_\_\_

Dialysis Center: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_

Dialysis Shift:  Mon Wed Fri  Tues Thurs Sat  1  2  3  4  Nocturnal

Previous organ transplant?  Yes  No

Organ Transplanted: \_\_\_\_\_

Date of Transplant: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Transplant Hospital: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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your application,  
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or toll-free 1-800-284-2185.**

**Mail to:** Methodist Dallas Medical Center  
Kidney/Pancreas Transplant Program  
PO Box 655999  
Dallas, TX 75265-5999  
**Fax:** 214-947-1828