PEDIATRIC TRANSPLANT APPLICATION

Type of Transplant:
☐ Kidney

PATIENT INFORMATION	
Name:	Date of Birth: Sex: ☐ Male ☐ Female
Social Security #:	Height: Weight:
U.S. Citizen: ☐ Yes ☐ No Resident Alien: ☐ Yes ☐ No	Language Preference:
Address: Apt.#	City: State: Zip:
Name of Parent/Guardian:	Phone #: Cell #:
Email: Emergency Contact:	Phone #:

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

INSURANCE INFORMATION	SECOND INSURANCE INFORMATION
Insured Name:	Insured Name:
Insurance Co. #:	Insurance Co. #:
Customer Service #:	Customer Service #:
Policy # / I.D. # Group #:	Policy # / I.D. # Group #:
Address:	Address:
City: State: Zip:	City: State: Zip:
Effective Date:	Effective Date:

REFERRING AGENTS	
Referring Physician:	Group Practice Name:
Address:	City: State: Zip:
Phone #:	Fax #:
Name of Dialysis Center:	Phone Number:
Dialysis Center Social Worker:	
Type of Dialysis: ☐ Not yet on dialysis ☐ Peritoneal ☐ Hemodialysis	
Dialysis Days: ☐ M/W/F ☐ T/Th/Sat	Dialysis Time: Dialysis Start Date:
Previous Transplant: ☐ Yes ☐ No	If Yes, Location: Date:

Consent - Patient Request to Begin Evaluation and Financial Clearance Process:

I request that Medical City Dallas Transplant Center begin the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start the transplant process.

Parent/Guardian Signature: _____ Witness Signature: _____

Print Name: _____ Date: _____ Print Name: _____ Date: _____

REQUIRED DOCUMENTS *(Please include a copy of the following required documents)*	
☐ Copy of the front and back of all insurance cards	☐ Copy of 2728 if currently receiving dialysis treatments
☐ Copy of your social security card	☐ Copy of most recent dialysis note
☐ Copy of your Texas I.D. or drivers license (if available)	☐ Copy of authorization of records release form
☐ Copy of your resident alien card (if applicable)	☐ Copy of current medication list

FAX REFERRAL FORM TO: 972.566.4872

Mail completed application to: Medical City Dallas • Transplant Institute • 7777 Forest Lane, Bldg. C-750
Dallas, Texas 75230 • 1-800-348-4218

Medical City Dallas Medical City Children's Hospital

7777 Forest Lane • Dallas, Texas 75230 • (972) 566-7000

TRANSPLANT APPLICATION PEDI

PATIENT IDENTIFICATION

* T P L S *

White - Medical City **Yellow -** Dialysis Center