

NAME:			
Social Security #:		Date of Birth:	
		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone #:		Cell #:	
		Email:	
U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No		Resident Alien: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Preference:			
Address:		Apt #:	
		City:	
		State:	
		ZIP:	
Height:		Weight:	
		lbs kg	
Emergency Contact:		Spouse:	
		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		Secondary Insurance Information	
Insurance Co.:		Insurance Co.:	
Customer Service #:		Customer Service #:	
Policy # / I.D. #:		Policy # / I.D. #:	
Group #:		Group #:	
Address:		Address:	
City:		City:	
State:		State:	
ZIP:		ZIP:	
Effective Date:		Effective Date:	
Referring Agents			
Referring Physician:		Group Practice Name:	
Address:		Phone #:	
City:		Fax #:	
State:			
ZIP:			
Dialysis Center:		Nephrologist:	
Phone #:		Dialysis Center Social Worker:	
Fax #:			
Type of Dialysis: <input type="checkbox"/> Not yet on dialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Home Hemodialysis			
Dialysis Days: <input type="checkbox"/> M/W/F <input type="checkbox"/> T/Th/S			
Dialysis Time:			
Centers in Evaluation/Listed for Transplant:			
Previous Transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Location:	
		Date:	
RELEASE OF INFORMATION – Patient Request to Begin Evaluation and Financial Clearance Process:			
<p>I request that Medical City Transplant Institute Fort Worth 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. I authorize my physicians to release my medical records to Medical City Transplant Institute Fort Worth. I authorize Medical City Transplant Institute Fort Worth 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:</p> <p>1) Medicare; 2) Medicaid; 3) my insurance company or its designated representatives; 4) any person (s) or entities financially responsible for my care or treatment. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred at Medical City Transplant Institute Fort Worth. I further authorize release of this information to health care providers associated with my care outside of Medical City Transplant Institute Fort Worth.</p>			
Patient Signature: _____		Witness Signature: _____	
Print Name: _____		Print Name: _____	
Date: _____		Date: _____	

Dear Potential Transplant Candidate, Social Worker, Charge Nurses, and Referring Physicians:

We thank you for your interest in evaluation at Medical City Transplant Institute | Fort Worth (MCTI). All applicable records listed below must be received before evaluation scheduling can occur. Please feel free to use this as a checklist and return it with the application.

- Completed application to the program
- Current History and Physical
- Current creatinine clearance (if patient has not initiated on dialysis)
- Most recent labs
- Proof of vaccinations
- Social work assessment from dialysis center
- Copy of ESRD Medical Evidence Report (2728 form – if on dialysis)
- Copy of Driver's License, Social Security Card, Resident Card (if applicable, and insurance cards
- Colonoscopy (males and females age 50 and above)
- Pap smear (females 21 and above, unless patient has had a hysterectomy)
- Mammogram (females age 40 and above)

Please fax all documents to MCTI at 469-713-8844. If you have any questions, please call the staff at MCTI at 817-834-8500.

Again thank you for choosing Medical City Transplant Institute | Fort Worth for your transplant care.