



MEMORIAL HERMANN  
TRANSPLANT CENTER

KIDNEY TRANSPLANT  
PATIENT APPLICATION

MEMORIAL HERMANN TRANSPLANT CENTER

*PLEASE COMPLETE FORM AND MAIL TO:*

MEMORIAL HERMANN HOSPITAL  
6411 FANNIN, SUITE JB600  
HOUSTON, TX 77030-1501

ATTENTION: RENAL TRANSPLANT DEPARTMENT

OR

FAX: 713-704-2910  
MAIN: 713-704-4071  
TOLL FREE: 800-869-5996

**Please also include:**

A copy of all insurance cards (front & back)

A copy of immunization records

A copy of current lab reports

**MEMORIAL HERMANN TRANSPLANT APPLICATION**

**PATIENT INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_  
GUARDIAN (IF APPLICABLE): \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELLULAR PHONE: \_\_\_\_\_  
SEX:  M  F RACE/ETHNICITY: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ARE YOU:  
 US CITIZEN  RESIDENT ALIEN  NON-RESIDENT ALIEN  
IF NON-RESIDENT ALIEN, COUNTRY: \_\_\_\_\_  
LANGUAGE: \_\_\_\_\_ IF OTHER THAN ENGLISH, DO YOU NEED AN INTERPRETER? \_\_\_\_\_  
HIGHEST LEVEL OF EDUCATION ATTAINED: \_\_\_\_\_  
HIGH SCHOOL GRADUATE OR GED: \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  
ARE YOU WORKING?  FULLTIME  PARTTIME  IN SCHOOL  NOT WORKING  
DO YOU:  WALK  REQUIRE CANE/WALKER  REQUIRE A WHEELCHAIR

**INSURANCE INFORMATION**

MEDICARE:  YES  NO  PENDING DATE APPLIED: \_\_\_\_\_  
MEDICARE #: \_\_\_\_\_ PART:  A  B EFFECTIVE DATE: \_\_\_\_\_  
MEDICARE PART D:  YES  NO PLAN NAME: \_\_\_\_\_  
MEDICAID:  YES  NO  PENDING DATE APPLIED: \_\_\_\_\_  
MEDICAID #: \_\_\_\_\_ PLAN NAME: \_\_\_\_\_  
HARRIS COUNTY GOLD CARD:  YES  NO TEXAS KIDNEY HEALTH:  YES  NO

PRIVATE INSURANCE COMPANY NAME: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
INSURED LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
MEMBER/ID #: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
VERIFICATION PHONE #: \_\_\_\_\_ PRE-CERTIFICATION PHONE #: \_\_\_\_\_

OTHER INSURANCE COMPANY NAME: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
INSURED LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
MEMBER/ID #: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
VERIFICATION PHONE #: \_\_\_\_\_ PRE-CERTIFICATION PHONE #: \_\_\_\_\_

**TRANSPLANT INFORMATION**

TYPE OF TRANSPLANT:     KIDNEY ONLY                       SIMULTANEOUS PANCREAS/KIDNEY  
                                  PANCREAS ONLY                       PANCREAS AFTER KIDNEY

IS THIS THE FIRST TIME YOU HAVE EVER BEEN EVALUATED FOR A KIDNEY TRANSPLANT?

YES                                       NO

IF NO, WHERE WERE YOU EVALUATED? \_\_\_\_\_ DATE \_\_\_\_\_

HAVE YOU HAD A PREVIOUS KIDNEY TRANSPLANT?

YES                                       NO

IF YES, WHICH TRANSPLANT CENTER? \_\_\_\_\_ DATE \_\_\_\_\_

IF YES, DO YOU KNOW THE REASON THE KIDNEY TRANSPLANT WAS LOST?

YES                                       NO

PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

DO YOU KNOW OF ANY PERSON/PERSONS WHO WOULD CONSIDER DONATING A KIDNEY TO YOU?

YES                                       NO

IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION ABOUT THE DONOR(S):

RELATIONSHIP TO THE RECIPIENT: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELLULAR PHONE: \_\_\_\_\_

SEX:  M  F    RACE/ETHNICITY: \_\_\_\_\_ DATE OF BIRTH/AGE: \_\_\_\_\_

RELATIONSHIP TO THE RECIPIENT: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELLULAR PHONE: \_\_\_\_\_

SEX:  M  F    RACE/ETHNICITY: \_\_\_\_\_ DATE OF BIRTH/AGE: \_\_\_\_\_

*PLEASE NOTE THAT THE DONOR MUST CONTACT A TRANSPLANT COORDINATOR  
AT 713-704-4071 TO BEGIN THE EVALUATION PROCESS*

**EMERGENCY CONTACT INFORMATION**

SPOUSE CONTACT INFORMATION:

SPOUSE LAST NAME: \_\_\_\_\_ SPOUSE FIRST NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ SPOUSE DATE OF BIRTH: \_\_\_\_\_

SPOUSE'S WORK PHONE: \_\_\_\_\_ SPOUSE'S CELLULAR PHONE: \_\_\_\_\_

EMERGENCY CONTACT PERSON:

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELLULAR PHONE: \_\_\_\_\_

NEAREST RELATIVE:

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELLULAR PHONE: \_\_\_\_\_

NEIGHBOR:

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELLULAR PHONE: \_\_\_\_\_

**REFERRAL INFORMATION**

HOW WERE YOU REFERRED TO MEMORIAL HERMANN HOSPITAL TRANSPLANT CENTER?

- NEPHROLOGIST     PRIMARY CARE PHYSICIAN     PEDIATRICIAN     ENDOCRINOLOGIST  
 DIALYSIS CENTER     OTHER

NEPHROLOGIST (KIDNEY PHYSICIAN) LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

PRIMARY CARE PHYSICIAN LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

CARDIOLOGIST LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

PEDIATRICIAN (IF APPLICABLE) LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

ENDOCRINOLOGIST LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

DIALYSIS CENTER NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_  
CONTACT PERSON: \_\_\_\_\_

**MEDICAL INFORMATION**

WHAT CAUSED YOUR RENAL FAILURE? \_\_\_\_\_  
WHAT IS YOUR CURRENT DRY WEIGHT? \_\_\_\_\_ HEIGHT: \_\_\_\_\_  
HAVE YOU EVER BEEN PREGNANT? \_\_\_\_\_ IF YES, HOW MANY TIMES? \_\_\_\_\_  
WHAT IS YOUR BLOOD TYPE? \_\_\_\_\_  POSITIVE     NEGATIVE  
HAVE YOU EVER HAD ANY BLOOD TRANSFUSIONS? \_\_\_\_\_ IF YES, HOW MANY? \_\_\_\_\_  
ARE YOU HIV POSITIVE?     YES     NO

ARE YOU ON DIALYSIS?     YES     NO  
IF YES, WHAT TYPE OF DIALYSIS?     HEMODIALYSIS     PERITONEAL  
IF NO, WHAT IS YOUR CURRENT SERUM CREATININE? \_\_\_\_\_  
WHEN DID YOU START DIALYSIS? \_\_\_\_\_

WHICH DAYS OF THE WEEK DO YOU GO TO DIALYSIS?  
 MONDAY-WEDNESDAY-FRIDAY     TUESDAY-THURSDAY-SATURDAY     DAILY  
 OTHER \_\_\_\_\_

WHAT TIME OF DAY DO YOU GO TO DIALYSIS?  
 MORNING     MIDDAY     AFTERNOON

HAVE YOU HAD OTHER FORMS OF DIALYSIS?  
HEMODIALYSIS:     YES     NO    HOW LONG? \_\_\_\_\_  
WHY DID YOU CHANGE? \_\_\_\_\_  
PERITONEAL DIALYSIS:     YES     NO    HOW LONG? \_\_\_\_\_  
WHY DID YOU CHANGE? \_\_\_\_\_

SINCE BEGINNING DIALYSIS, HAVE YOU EVER BEEN HOSPITALIZED?  YES  NO  
IF YES, PLEASE EXPLAIN:

DATE: \_\_\_\_\_ REASON: \_\_\_\_\_  
DATE: \_\_\_\_\_ REASON: \_\_\_\_\_  
DATE: \_\_\_\_\_ REASON: \_\_\_\_\_

DO YOU HAVE A FUNCTIONING:  A-V GRAFT  A-V FISTULA  
 CENTRAL LINE  PERITONEAL CATHETER

HAVE YOU HAD MORE THAN ONE?  YES  NO IF YES, HOW MANY? \_\_\_\_\_  
WHERE IS YOUR CATHETER/GRAFT/FISTULA LOCATED? \_\_\_\_\_  
DATE OF YOUR LAST REVISION: \_\_\_\_\_ HOW MANY CENTRAL LINES HAVE YOU HAD? \_\_\_\_\_  
HAVE YOU HAD PERITONITIS?  YES  NO IF YES, HOW MANY TIMES? \_\_\_\_\_  
WHEN WAS YOUR LAST PERITONITIS? \_\_\_\_\_  
HAVE YOU HAD ANY PROBLEMS WITH YOUR DIALYSIS ACCESS?  YES  NO  
IF YES,  INFECTION  CLOTS

PLEASE LIST ANY ALLERGIES:

DRUG _____	REACTION _____
DRUG _____	REACTION _____
DRUG _____	REACTION _____
FOOD _____	REACTION _____
FOOD _____	REACTION _____
FOOD _____	REACTION _____

PLEASE LIST CURRENT MEDICATIONS:

DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____
DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____
DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____
DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____
DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____
DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____
DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____
DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____
DRUG _____	DOSE _____	HOW MANY TIMES A DAY? _____

PLEASE LIST ANY SURGERIES THAT YOU HAVE HAD IN YOUR LIFETIME:

SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____
SURGERY _____	YEAR _____

PLEASE LIST ANY MAJOR INJURIES OR BROKEN BONES:

INCIDENT \_\_\_\_\_ YEAR \_\_\_\_\_  
INCIDENT \_\_\_\_\_ YEAR \_\_\_\_\_  
INCIDENT \_\_\_\_\_ YEAR \_\_\_\_\_

DO YOU HAVE DIABETES (HIGH BLOOD SUGAR):  YES  NO

IF YES, WHAT TYPE?  TYPE I  TYPE II

WHAT IS YOUR MOST RECENT HEMOGLOBIN A1C? \_\_\_\_\_

HOW MANY TIMES A DAY DO YOU CHECK YOUR BLOOD SUGAR? \_\_\_\_\_

WHAT IS YOUR BLOOD SUGAR RANGE ON A DAILY BASIS? \_\_\_\_\_

DO YOU TAKE INSULIN?  YES  NO

IF YES, HOW LONG HAVE YOU BEEN TAKING INSULIN? \_\_\_\_\_

HOW MANY TIMES A DAY DO YOU TAKE INSULIN? \_\_\_\_\_

HOW OFTEN DO YOU HAVE SIGNIFICANT EPISODES OF LOW BLOOD SUGAR? \_\_\_\_\_

ARE YOU ALWAYS AWARE WHEN YOUR BLOOD SUGAR GETS LOW?  YES  NO

DO YOU HAVE RETINOPATHY (EYE DAMAGE)?  YES  NO

DO YOU HAVE NEUROPATHY (NERVE DAMAGE/NUMBNESS)?  YES  NO

DO YOU HAVE GASTROPARESIS (SLOW DIGESTION)?  YES  NO

DO YOU HAVE LEG/FOOT ULCERS?  YES  NO

DO YOU HAVE HEART PROBLEMS?  YES  NO

HEART ATTACKS?  YES  NO

BYPASS SURGERY?  YES  NO

VASCULAR SURGERY?  YES  NO

ANGINA OR CHEST PAIN?  YES  NO

PALPITATIONS?  YES  NO

HEART RHYTHM PROBLEMS?  YES  NO

DO YOU HAVE LUNG PROBLEMS?  YES  NO

ASTHMA?  YES  NO

BRONCHITIS?  YES  NO

PNEUMONIA?  YES  NO

DO YOU HAVE GASTROINTESTINAL PROBLEMS?  YES  NO

STOMACH ULCERS?  YES  NO

CROHN'S DISEASE?  YES  NO

ULCERATIVE COLITIS?  YES  NO

DIVERTICULITIS?  YES  NO

DO YOU HAVE HYPERTENSION (HIGH BLOOD PRESSURE)?  YES  NO

HOW LONG HAVE YOU HAD HYPERTENSION? \_\_\_\_\_

HOW LONG HAVE YOU BEEN TAKING MEDICATION FOR HYPERTENSION? \_\_\_\_\_

DO YOU HAVE LIVER PROBLEMS?  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

DO YOU HAVE GALLBLADDER PROBLEMS?  YES  NO

DO YOU HAVE ANY OF THE FOLLOWING?

URINARY TRACT INFECTIONS?  YES  NO

URINARY TRACT ABNORMALITIES?  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

FEMALE REPRODUCTIVE ORGAN PROBLEMS?  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

MALE REPRODUCTIVE PROBLEMS?  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

BLEEDING OR CLOTTING PROBLEMS?  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

SICKLE CELL OR SICKLE CELL TRAIT DISEASE?

YES  NO

LUPUS?

YES  NO

IF YES, HAS IT AFFECTED ANY OF THE FOLLOWING?

BRAIN  JOINTS  KIDNEY  SKIN

OPEN WOUND OR ULCER?

YES  NO

IF YES, WHERE? \_\_\_\_\_

AMPUTATIONS?

YES  NO

IF YES, WHERE? \_\_\_\_\_

STROKE?

YES  NO

CANCER?

YES  NO

PRESENT  PAST WHAT TYPE? \_\_\_\_\_

HEPATITIS?  A  B  C

HAVE YOU HAD THE HEPATITIS VACCINE?

YES  NO

ARE YOU CURRENTLY BEING TREATED FOR AN INFECTION?

YES  NO

ANY OTHER MEDICAL PROBLEMS, PLEASE EXPLAIN: \_\_\_\_\_

HAVE YOU BEEN TREATED FOR DEPRESSION?

YES  NO

IF YES, HOW LONG? \_\_\_\_\_

DO YOU SMOKE?

YES  NO

# PACKS/DAY \_\_\_\_\_

DO YOU DRINK ALCOHOL?

YES  NO

# DRINKS/DAY \_\_\_\_\_

HAVE YOU EVER USED RECREATIONAL DRUGS?

YES  NO

WHEN/DATE? \_\_\_\_\_ WHAT TYPE? \_\_\_\_\_

HAVE YOU EVER BEEN TO JAIL?

YES  NO

FAMILY MEDICAL HISTORY

RELATIONSHIP TO YOU

DIABETES?

YES  NO

HYPERTENSION?

YES  NO

POLYCYSTIC KIDNEYS?

YES  NO

RENAL FAILURE?

YES  NO

HEART DISEASE?

YES  NO

LIVER DISEASE?

YES  NO

CANCER?

YES  NO

OTHER DISEASES/ABNORMALITIES?

YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

