Methodist
Transplant Center

For Patient Referral:
(713) 441-5451 **(888) 393-3986**

☐ **KIDNEY** ☐ **KIDNEY/PANCREAS** ☐ **PANCREAS** ☐ **SPANISH**

Patient Demographics **Referral Date**_____

Name_____SSN_____
Address_____
City_____ State_____ ZIP_____
Date of Birth _____ Gender ☐ M ☐ F Race_____ Marital Status ☐M ☐S ☐D ☐W
Home Phone _____ Work Phone _____
Alternate Phone_____ E-mail _____
Emergency Contact_____Relationship_____
Contact Phone_____Contact Alternate Phone_____
Referring MD _____
Referring MD Phone _____ Referring MD FAX _____
Dialysis Type ☐ Hemo ☐ PD Comments:_____
Dialysis Days ☐ M-W-F ☐ T-Th-Sa Comments:_____
Dialysis Start Date _____ Access Type ☐Catheter ☐Fistula ☐Graft
Dialysis Center Name_____ Phone Number_____
Address_____
City_____ State_____ ZIP_____ FAX: _____
HT_____WT_____BMI_____
Primary Care Physician Name_____PCP Number_____

Insurance Information

Patient is insured party ☐ Yes ☐ No Cobra ☐ Yes ☐ No
Name of Insurance Carrier_____
Group Name_____Policy Number_____
Group Number_____Phone Number_____

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Group Name_____Policy Number_____
Group Number_____Phone Number_____

If Insured other than patient- Name_____DOB_____
SS# _____
Employer_____ Employer Phone_____

Medicare Number_____ Effective Date_____
Medicare Part D ☐ Yes ☐ No Medicare Part D Number_____
Plan Name_____Phone Number_____

Medicaid Plan_____Recipient Number_____

ESRD= End Stage Renal DiseaseCA= Cancer HTN=Hypertension DM = Diabetes Mellitus
Liver DZ= Liver disease

Social History

Years of Education: ☐ None ☐ Grade School ☐ High School ☐ Some College ☐ College grad ☐ Post grad

Currently working? ☐ No ☐ Yes ☐ Full-time ☐ Part-time Occupation: _____

Employer_____ Years at Occupation _____

Disability Status ☐ Yes ☐ No Disability Start Date: _____

ETOH History ☐ None ☐ Abuse Type _____ Yr. Started_____ Yr. Stopped_____

Smoking History ☐ None PPD _____ Yr. Started_____ Yr. Stopped_____

Drug Use ☐ None Type_____ Yr. Started_____ Yr. Stopped_____

Exercise ☐ None Type_____ Yr. Started_____ Yr. Stopped_____

Medical History

Original Disease: ☐ HTN ☐ DM ☐ Other: _____

Biopsy Results: ☐Yes ☐No Date: _____

Allergies ☐NDKA ☐Yes _____ Latex gloves : ☐Yes : ☐No

Other: _____

Previous Transplant? ☐ Yes ☐ No Comments_____

Transplant Date_____ Transplant Date_____

Type_____Side_____ Type_____Side_____

Date Rejected_____ Date Removed_____ Date Rejected_____ Date Removed_____

Previous Transfusions? ☐ Yes ☐ No How many? _____ Date of last _____

No. of pregnancies _____ No. of live births_____ Mammogram ☐Yes ☐No Date: _____

Location: ☐TMH ☐Other: _____ If yes: Breast implants ☐Yes ☐No Catheter ☐Yes ☐No

HTN (Hypertension)	☐ Yes	☐ No	Age of Onset _____	Comments_____
Diabetes	☐ Yes	☐ No	Age of Onset _____	Type of Meds: _____
Anemia	☐ Yes	☐ No	Age of Onset _____	Comments_____
Tuberculosis (TB)	☐ Yes	☐ No	Age of Onset _____	Comments_____
Lung Disease	☐ Yes	☐ No	Age of Onset _____	Comments_____
Heart Disease	☐ Yes	☐ No	Age of Onset _____	Comments_____
Bone Disease	☐ Yes	☐ No	Age of Onset _____	Comments_____
Peptic Ulcer Disease	☐ Yes	☐ No	Age of Onset _____	Comments_____
Hepatitis	☐ Yes	☐ No	Age of Onset _____	Comments_____
	Type ☐ A ☐ B ☐ C			
Cancer	☐ Yes	☐ No	Age of Onset _____	Comments_____
	Type_____			
HIV	☐ Yes	☐ No	Age of Onset _____	Comments_____

Surgical History

Previous surgeries Date Where?

1. _____
2. _____
3. _____
4. _____

Family History

Mother: ☐ ESRD ☐ CA ☐ HTN ☐ DM ☐ Liver DZ **Grandmother:** ☐ ESRD ☐ CA ☐ HTN ☐ DM ☐ Liver DZ
Father: ☐ ESRD ☐ CA ☐ HTN ☐ DM ☐ Liver DZ **Grandfather:** ☐ ESRD ☐ CA ☐ HTN ☐ DM ☐ Liver DZ
Children: ☐ ESRD ☐ CA ☐ HTN ☐ DM ☐ Liver DZ **Brothers:** ☐ ESRD ☐ CA ☐ HTN ☐ DM ☐ Liver DZ
Sisters: ☐ ESRD ☐ CA ☐ HTN ☐ DM ☐ Liver DZ

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