AUGUSTA
UNIVERSITY

Dear Potential Transplant Candidate:

Thank you for your interest in the kidney and pancreas transplant program at Augusta University. In order to begin the evaluation process, we need to gather some basic information about you. Please fill out the attached forms and return them to our office as soon as possible in the enclosed envelope.

Once we receive these forms, we will review your insurance coverage and begin gathering information on your medical history. These forms must be received before you can proceed to Evaluation. If you need assistance completing these forms, please contact our office at 706-721-2888.

Please feel free to contact our office at any time if you have questions regarding your status or our referral process. Do not hesitate to contact us with questions or concerns or if you are no longer interest in pursuing a kidney transplant.

Thank you for allowing us to help you through this process and choosing the Augusta University Kidney and Pancreas Transplant Program.

Sincerely,

Kidney Pancreas Transplant Team

Enclosures:
Insurance Forms
Medical Questionnaire
Medical Release of Information
Postage Paid Return Envelope

KIDNEY AND PANCREAS TRANSPLANT PROGRAM

Mailing Address:
1120 15th Street, AD 3401
Augusta, Georgia 30912

T (706) 721-2888 | (800) 736-2273 ext 2888

F (706) 721-1394 main | (706) 721-6271 referrals

augustahealth.org

AUGUSTA
UNIVERSITY

Please fill out the following insurance information form. Please do not hesitate to call one of our financial counselors at 706-721-2888 if you have any questions.

Name: _____ Date of Birth: __/__/____

Social Security #: ____-____-____ Preferred Contact Number: (____) ____-____

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced/separated

Employment Status: ☐ full-time ☐ part-time ☐ retired ☐ unemployed/disabled

Company Name: _____

Primary Insurance: _____

Policy # _____ Group # _____

Contact phone # _____

Subscriber's name: _____ Date of Birth: __/__/____

Relationship to patient: ☐ self ☐ spouse ☐ other: _____

Is this a COBRA Plan? ☐ yes, effective date: __/__/____ ☐ no

Does someone other than the insured pay the premiums? ☐ yes ☐ no

Secondary Insurance: _____

Policy # _____ Group # _____

Contact phone # _____

Subscriber's name: _____ Date of Birth: __/__/____

Relationship to patient: ☐ self ☐ spouse ☐ other: _____

Is this a COBRA Plan? ☐ yes, effective date: __/__/____ ☐ no

Does someone other than the insured pay the premiums? ☐ yes ☐ no

Prescription Drug Coverage: _____

Policy # _____ Group # _____

Contact phone # _____

Mailing Address:
1120 15th Street, AD 3401
Augusta, Georgia 30912

T (706) 721-2888 | (800) 736-2273 ext 2888

F (706) 721-1394 main | (706) 721-6271 referrals

augustahealth.org

Transplant Candidate Questionnaire

AUGUSTA UNIVERSITY Transplant Program

Date Completed: _____ Completed by: _____ Relationship to patient: _____

The information provided in this form will assist us in entering the appropriate information into our transplant medical system as well as providing baseline information for your transplant evaluation clinic visit. Please use a black ink pen.

PATIENT INFORMATION				
Last Name:	First Name:		Middle:	
Date of Birth:	Race:		Citizenship:	
Marital Status: ❑ Single	❑ Married	❑ Widowed	❑ Divorced	❑ Separated
Primary Language:		Will you need an interpreter?	❑ Yes	❑ No
Email Address:		Education:		
Employment: ❑ Full Time	❑ Part Time	❑ Retired	❑ Disabled	❑ Not Working
Occupation (current or prior):		Employer:		

PHYSICIANS AND CARE PROVIDERS			
	***Name** (first and last)*	***Date Last Seen***	***Contact Information***
Primary Care			
Nephrologist			
Cardiologist			
Vascular Surgeon			
Urologist			
Cancer Specialist			
Dermatologist			
Rheumatologist			
Dentist			
OB/GYN (if female)			
Other physicians:			

KIDNEY DISEASE HISTORY		
What is the cause of your kidney disease?		
Have you ever had a kidney biopsy?	❑ Yes	❑ No
If Yes, What Hospital?	When?	
Have you previously had a kidney transplant?	❑ Yes	❑ No
If Yes, What Hospital? _____	When? _____	
Why did your transplant fail?		
Are you on dialysis?	❑ Yes	❑ No
If Yes, type: ❑ Clinic Hemodialysis ❑ Home Hemodialysis ❑ Peritoneal Dialysis		
If No, What is your kidney function (eGFR)?		

Are you currently being evaluated at another transplant center?	❑ Yes	❑ No
If Yes, Name of center:		
Are you currently listed at another transplant center?	❑ Yes	❑ No
If Yes, Name of center:		

PAST SURGICAL HISTORY		
Type of Surgery	Date	Hospital

PAST HISTORY				
Diabetic History (if not applicable, skip to next section)				
How old were you when first diagnosed with diabetes?				
How often do you check your blood sugar? Times per day: Times per week: ❑ Don't Check				
Have you been on: ❑ Insulin ❑ Pills *or* ❑ Both For how long?				
Total units of insulin per day: Do you require assistance with injections?			❑ Yes	❑ No
Do you have any open wounds?			❑ Yes	❑ No
Have you been admitted for hyperglycemia or hypoglycemia within the past two years?			❑ Yes	❑ No
Have you had eye problems as a result of diabetes (retinopathy)?			❑ Yes	❑ No
Have you had nerve problems as a result of diabetes (neuropathy)?			❑ Yes	❑ No
Have you ever had stomach/intestinal problems as a result of your diabetes (gastroparesis)?			❑ Yes	❑ No
Do you have a history of foot ulcers?			❑ Yes	❑ No
Do you have a history of amputations?			❑ Yes	❑ No
Can you usually tell when your blood sugar is too low without checking it?			❑ Yes	❑ No
Have you ever blacked out or seized from a low blood sugar?			❑ Yes	❑ No
What is your HgbA1C? ❑ Don't Know				
Cardiovascular				
Any history of the following…			***Date(s)***	***Hospital***
Hypertension	❑ Yes	❑ No		
Myocardial infarction (heart attack)	❑ Yes	❑ No		
Abnormal heart rhythm	❑ Yes	❑ No		
Congestive heart failure	❑ Yes	❑ No		
Cardiac stress test	❑ Yes	❑ No		
Cardiac Cath? ❑ Yes ❑ No With Stents?	❑ Yes	❑ No		
Carotid surgery or angioplasty	❑ Yes	❑ No		
Heart bypass surgery	❑ Yes	❑ No		
Bypass surgery or stenting of leg vessels	❑ Yes	❑ No		
Defibrillator or pace maker	❑ Yes	❑ No		
Other history:				

Neuro/Psychiatric Disease				
Have you been diagnosed with…			***Date(s)***	***Hospital***
Stroke/CVA or mini stroke/TIA	❑ Yes	❑ No		
Paralysis	❑ Yes	❑ No		
Neuropathy	❑ Yes	❑ No		
Memory loss	❑ Yes	❑ No		
Depression/anxiety/panic attacks	❑ Yes	❑ No		
Ongoing psychiatric follow-up?	❑ Yes	❑ No		
Seizures	❑ Yes	❑ No		
Other history:				

Lung Disease					
Do you have lung problems?	❑ Yes	❑ No	Type:		
Do you use oxygen?	❑ Yes	❑ No	Liters:		
Do you use CPAP?	❑ Yes	❑ No	Do you use Inhalers?	❑ Yes	❑ No
Have you had PFTs (pulmonary function tests)?	❑ Yes	❑ No	Date:	Hospital:	
Other history:					

GI/Gastrointestinal				
Have you been diagnosed with…			***Date(s)***	***Hospital***
GI bleed	❑ Yes	❑ No		
EGD performed	❑ Yes	❑ No		
Colonoscopy performed	❑ Yes	❑ No		
Colon disease	❑ Yes	❑ No		
Pancreas disease	❑ Yes	❑ No		
Gallbladder disease	❑ Yes	❑ No		
Other history:				

Blood Disorders					
Type			***Date Diagnosed***	***Received Treatment***	
Sickle cell	❑ Yes	❑ No		❑ Yes	❑ No
Blood clots (other than dialysis access)	❑ Yes	❑ No		❑ Yes	❑ No
Filter placed to prevent clots	❑ Yes	❑ No		❑ Yes	❑ No
Blood thinners to treat clots	❑ Yes	❑ No		❑ Yes	❑ No
Blood transfusions	❑ Yes	❑ No	Approx #:	Date of last:	
Other history:					
Would you be willing to accept Blood Products if necessary?				❑ Yes	❑ No

Infections				
❑ Hepatitis B	❑ Hepatitis C	❑ If yes, prior liver biopsy?	Date:	Hospital:
❑ HIV	❑ STDs	❑ Tuberculosis (TB)	Other history:	

Urinary					
Bladder surgery	❑ Yes	❑ No	Kidney Stones	❑ Yes	❑ No
Prostate enlargement (BPH)	❑ Yes	❑ No	Nephrectomy	❑ Yes	❑ No
Prostate surgery	❑ Yes	❑ No	Urinary tract infections	❑ Yes	❑ No

Other history:				
Musculoskeletal				
Amputations	❑ Yes	❑ No	*If yes,* Where:	
Open wounds	❑ Yes	❑ No		
Other history:				
Obstetrics and Gynecology (women only)				
Number of pregnancies:			Number of deliveries:	
Hysterectomy	❑ Yes	❑ No	Facility:	Date:
Date of last Pap Smear:			Facility:	
Date of last Mammogram:			Facility:	
Other history:				

Cancer History				
Type			***Describe***	***Date***
Bladder	❑ Yes	❑ No		
Blood cancers (leukemia, lymphoma, myeloma)	❑ Yes	❑ No		
Breast	❑ Yes	❑ No		
Colon / Gastrointestinal	❑ Yes	❑ No		
Kidney	❑ Yes	❑ No		
Lung	❑ Yes	❑ No		
Prostate	❑ Yes	❑ No		
Skin	❑ Yes	❑ No		
Other history:				
Received chemotherapy	❑ Yes	❑ No		
Received radiation	❑ Yes	❑ No		
Other Medical Problems				
Arthritis	❑ Yes	❑ No		
Hernia	❑ Yes	❑ No		
High cholesterol	❑ Yes	❑ No		
Lupus	❑ Yes	❑ No		
Thyroid problems	❑ Yes	❑ No		
Other history:				

Dental History					
Do you see a dentist for routine cleanings/checkups?				❑ Yes	❑ No
Any history of:	❑ Cavities	❑ Extractions	❑ Dentures	❑ Infections	
If yes, describe:					

SOCIAL HISTORY				
Tobacco Use				
Do you or have you ever smoked cigarettes?			❑ Yes	❑ No
If yes, How many packs per day?		How many years?		
Date started:		Date quit:		
Alcohol Use				
Do you or have you ever consumed alcohol on a regular basis?			❑ Yes	❑ No
If yes, How much each day?		How many days/month?	How many years?	
Date started:		Date quit:		
Substance Use				
Please indicate any of the substances that you have used and last use if applicable:				
❑ Marijuana	❑ Cocaine/Crack	❑ Heroin or narcotics	❑ Stimulants, sedatives, or diet pills	
Last use:	Last use:	Last use:	Last use:	
Support System				
Who do you live with?	Name	Relationship		
	Name	Relationship		
	Name	Relationship		
	Name	Relationship		
Do you work?	❑ Yes ❑ No	*If yes,* Where		
Do you have a car?	❑ Yes ❑ No	Do you drive?	❑ Yes	❑ No
Does anyone in the household have a car?			❑ Yes	❑ No
Have you ever used Medicaid transportation?			❑ Yes	❑ No
If on dialysis, how do you currently travel to the center?				
In order to avoid any delays in your transplant listing process you will need to bring a support person to your evaluation appointment.				
Who will accompany you to your transplant evaluation appointment?	Name			
	Relationship			
	Contact #			
You will be unable to drive for approximately four weeks following your transplant.				
Who will bring you to Augusta University Medical Center when you are called for a kidney transplant?	Name			
	Relationship			
	Contact #			
Who will be staying with you at home after your transplant surgery?	Name			
	Relationship			
	Contact #			
You will be required to travel to Augusta for clinic visits after your transplant. You will come for about 13 clinic visits during the first three months, at first, <u>two times a week</u>.				
Who will bring you to Augusta for the required clinic visits?	Name			
	Relationship			
	Contact #			

SELF ASSESSMENT					
How are you feeling today?			❑ Good	❑ Fair	❑ Poor
Do you have any pain?				❑ Yes	❑ No
If yes, Rate the pain on a scale of 0 to 10, 0 being no pain and 10 being worst pain possible: 1 2 3 4 5 6 7 8 9 10					
What is your energy level?				❑ Normal	❑ Low
Have you experienced any unplanned weight changes?				❑ Yes	❑ No
If yes, ❑ Loss ❑ Gain					
Rate your general health:			❑ Excellent	❑ Good	❑ Poor
Activity Level					
Are you able to:					
Drive yourself	❑ Yes	❑ No	Shop at grocery store	❑ Yes	❑ No
Dress yourself	❑ Yes	❑ No	Perform housekeeping	❑ Yes	❑ No
Feed yourself	❑ Yes	❑ No	Cook / food preparation	❑ Yes	❑ No
Maintain hygiene	❑ Yes	❑ No	Handle finances/pay bills	❑ Yes	❑ No
Lift a 10 pound bag	❑ Yes	❑ No			
Exercise	❑ Yes	❑ No	*If yes,* Describe:		
Additional Health Questions					
Do you receive assistance from home health services?				❑ Yes	❑ No
Do you use any assistive devices?				❑ Yes	❑ No
If yes, ❑ Oxygen ❑ Walker/Cane ❑ Wheelchair ❑ CPAP ❑ Prosthetics Other:					
Have you been admitted to a nursing home or rehab facility within the past 12 months?				❑ Yes	❑ No
How far can you walk without difficulty? ❑ Football field			❑ ½ track lap (600 ft)	❑ Full track lap (900 ft)	
How often do you miss hemodialysis in a month?			*If yes,* Why?		
How often do you miss your medication in a week?			*If yes,* Why?		
Have you experienced any falls in the past 12 months?				❑ Yes	❑ No
Do you have a healthcare proxy?				❑ Yes	❑ No
If yes, Name			Details		

AUGUSTA UNIVERSITY

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I Hereby Authorize AU Health **to request, use or disclose** my Protected Health Information from the following hospital/physician(s) listed below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name: _____
First Middle Last

Social Security Number: _____ Date of Birth: _____

HOSPITAL/PHYSICIAN	**REQUEST**

Purpose of Disclosure: Transplant Evaluation

Dates of Treatment: ALL HOSPITALIZATIONS DISCHARGE SUMMARIES: ____

Information to be Used/Disclosed – Please check those that apply: More detailed information may be requested.

History and Physical	____	Discharge Summary	____	Operative Report	____	Other (specify)	_____
Progress Notes	____	Laboratory Report	____	Radiology Report	____	Immunization Record	____
Billing Summary	____	Consultation Report	____	Pathology Report	____	Entire Medical Record	____

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases Including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility.

AU Health may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization; or
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

X _____ _____
Signature of Patient or Legally Qualified Representative Date

_____
Relationship of Legally Qualified Representative

KIDNEY AND PANCREAS TRANSPLANT PROGRAM

Mailing Address:
1120 15th Street, AD 3401
Augusta, Georgia 30912

T (706) 721-2888 | (800) 736-2273 ext 2888

F (706) 721-1394 main | (706) 721-6271 referrals

augustahealth.org