Methodist
DALLAS TRANSPLANT INSTITUTE

Application

Methodist Dallas Medical Center Recipient Application for Organ Transplant

All pages must be filled out completely and signed in order to process your application.
If your application is incomplete, it will be returned to you, which will delay the processing of your request.

For assistance in filling out your application, please call 214-947-1800 or toll-free 1-800-284-2185.

Application for (check all organs that apply): ☐ Kidney ☐ Pancreas ☐ Liver/Kidney

Possible donor sources: ☐ Living Related ☐ Living Unrelated ☐ Deceased Donor ☐ Paired Donor Exchange

Who referred you to Methodist? ☐ Physician ☐ Insurance ☐ Self ☐ Other

PHYSICIAN INFORMATION

Your kidney doctor: _____ Phone: ( ) _____

Address: _____

Primary care physician: _____ Phone: ( ) _____

Address: _____

PATIENT INFORMATION

Name: _____ SS#: _____
LAST FIRST MIDDLE (MAIDEN) SOCIAL SECURITY #

Mailing address: _____
STREET ADDRESS APT. #

_____
CITY STATE ZIP

Home phone: ( ) _____ Mobile Phone: ( ) _____

Email: _____

DOB: _____ / _____ / _____ Age: _____ Sex: _____

Religion: _____ Race: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient employed by: _____ Work phone: ( ) _____

Work Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled

Is patient a U.S. Citizen? ☐ Yes ☐ No If "no," what country? _____

Does patient speak English? ☐ Yes ☐ No If "no," what language? _____

SPOUSE OR PARENT (IF MINOR) INFORMATION

Name: _____ SS#: _____

Relationship to patient: _____

Employer: _____ Work phone: ( ) _____

Alternate contact person:

Name: _____ Phone: ( ) _____

Relationship to patient: _____

INSURANCE INFORMATION

MEDICARE I.D.: _____ Effective date: ____ / ____ / ____

Medicare Due To (Check One): ☐ Kidney disease ☐ Age

Social security disability: _____

Medicaid I.D.: _____ Effective date: ____ / ____ / ____

Texas residents only
Texas Kidney Healthcare I.D.: _____

INSURANCE COMPANY ONE

☐ HMO ☐ PPO ☐ POS ☐ Indemnity Effective date: ____ / ____ / ____

Insurance company name: _____

Name of group/employer: _____

Group #: _____ Policy #: _____

Insurance benefits phone number: _____

Insurance company address: _____

_____

Name of insured person: _____

Relationship to patient: _____

Date of birth of insured: ____ / ____ / ____ SS# of insured person: _____

Other I.D. number: _____

INSURANCE COMPANY TWO

☐ HMO ☐ PPO ☐ POS ☐ Indemnity Effective date: ____ / ____ / ____

Insurance company name: _____

Name of group/employer: _____

Group #: _____ Policy #: _____

Insurance benefits phone number: _____

Insurance company address: _____

_____

Name of insured person: _____

Relationship to patient: _____

Date of birth of insured: ____ / ____ / ____ SS# of insured person: _____

Other I.D. number: _____

Are you currently listed at another transplant center? ☐ Yes ☐ No

Transplant center: _____

Address: _____

_____
CITY STATE ZIP

Contact person: _____ Phone: _____

DIALYSIS INFORMATION

Primary diagnosis *(example: diabetes, FSGS, hypertension)* _____

Currently on dialysis? ☐ Yes ☐ No

Date current dialysis began: _____ / _____ / _____

Type of dialysis (check one): ☐ Home hemo ☐ PD ☐ In-center hemo _____

Dialysis center: _____

Address: _____

Phone number: _____

Dialysis Shift: ☐ Mon Wed Fri ☐ Tues Thurs Sat Shift ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Nocturnal

Please let your social worker make a copy of this application.

Previous organ transplant? ☐ Yes ☐ No

Organ transplanted: _____

Date of transplant: _____ / _____ / _____

Transplant hospital: _____

_____ Date: _____ / _____ / _____
SIGNATURE

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your application,
please call 214-947-1800
or toll-free 1-800-284-2185.

Mail to: Methodist Dallas Medical Center
Kidney/Pancreas Transplant Program
PO Box 655999
Dallas, TX 75265-5999

Fax: 214-947-1828