TRANSPLANT PATIENT INFORMATION
(MUST BE COMPLETED AND RETURNED WITHIN ONE WEEK OF RECEIVING)

Name: ______________________________ **Date:** ______________________

Address: ______________________________ **City**______________ **State**________ **Zip**____________

Contact Phone Number: ____

How many miles from your home is the Oklahoma Transplant Center? ______________________________

EVALUATION TYPE **(Check all that apply)**

- ☐ Kidney ☐ Pancreas ☐ Liver ☐ New Evaluation ☐ Annual Evaluation

INSURANCE PROVIDER **(Check all that apply)**

- ☐ Medicare ☐ Medicaid/Sooner Care ☐ ACA Plan ☐ Indian Health ☐ Commercial Insurance ☐ Other____________

FAMILY BACKGROUND (Please provide name and phone number for all)

- Marital/Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other ______________________
  Name: ____
- Parents: ____
- Siblings: ____
- Children: ____
- Additional Support: ____

LIVING DONOR(S) (Kidney ONLY)

- Who will be your living donor? (Name and Relationship) ______________________________

TRANSPORTATION

- Do you have a valid license? ☐ Yes ☐ No
- Do you drive? ☐ Yes ☐ No
- How do you get to and from medical appointment, grocery store, etc? ______________________________
- Do you have access to and/or utilize sooner ride or sooner ride mileage reimbursement? ______________________

RELIGIOUS/SPIRITUAL

- Do you belong to a religious/spiritual community? (Church, Temple, Mosque, Synagogue) ☐ Yes ☐ No
  (If yes, name of institution.) ______________________________________
- Do you have any personal, religious or spiritual beliefs that would hinder your healthcare in any way? ☐ Yes ☐ No

HOME ENVIRONMENT

- Type of Residence: ☐ Mobile Home ☐ Apartment ☐ Single Family Home ☐ Nursing Home/Assisted Living ☐ Section 8
- Who lives in your home with you? ______________________________________
- Do you have any pets? ☐ Yes ☐ No (If yes, what kind(s) and how many?) ______________________________
- Do you have any stairs? ☐ Yes ☐ No
- Are your bedroom and bathroom on the same floor? ☐ Yes ☐ No
- Are all of your utilities in good working order? ☐ Yes ☐ No
- Do you have any structural damage? (Leaking windows/roof, mold, etc.) ☐ Yes ☐ No
- Do you have any assistive devices in the home? (Ramps, grab bars, lift chairs, etc.) ☐ Yes ☐ No

EMPLOYMENT/RETIREMENT/DISABILITY **(Check all that apply)**

- ☐ Full time ☐ Part time ☐ Retired ☐ Student ☐ Unemployed ☐ SSI ☐ SSDI ☐ Military Disability ☐ Short-term disability ☐ Long-term disability ☐ Workers Comp ☐ Unemployed ☐ Looking for work
- Name of current or last employer______________________________ Start Date: _______ End Date:_______
- Do you have access to: ☐ Paid time off ☐ FMLA ☐ Short-term disability ☐ Long-term disability ☐ N/A
- Do you plan to return to work after transplant? ☐ Yes ☐ No ☐ N/A

- Do you have any concerns about your job post-transplant? ☐ Yes ☐ No ☐ N/A
- How do you plan to cover your expenses while off work? ___________________________
- If you are on disability, what is your disability based on and when were you deemed disabled? ___________________________

FINANCIAL

- Is your current income enough to pay your living expenses (housing, utilities, food, meds, etc?) ☐ Yes ☐ No
- What do you do when you do not have enough money during the month to pay your bills? ___________________________
- Do you receive food stamps? ☐ Yes ☐ No
- Do you have any payday loans/finance loans? ☐ Yes ☐ No
- Will your caregiver being off work have an effect on your income? ☐ Yes ☐ No

MILITARY SERVICE

- Have you served in the military? ☐ Yes ☐ No Branch: __________ Years of Service: ____ Discharge Disposition: ___________
- Do you use the VA Clinic? ☐ Yes ☐ No ☐ N/A

EDUCATION

- What was the highest grade you completed in school? ___________________________
- Are you able to read/write/comprehend English? ☐ Yes ☐ No
- What is your native language? ______________ Do you read/write/comprehend in your native language? ☐ Yes ☐ No
- Do you require an interpreter? ☐ Yes ☐ No

CITIZENSHIP

- Where you born in the United States? ☐ Yes ☐ No
- What year did you move to the US? ___________________________
- What is your current citizenship status? ☐ Permanent Resident ☐ Naturalized Citizen ☐ Undocumented ☐ Work/Student Visa
- Date of Approval: ___________________________ Date of Expiration: ___________________________
- Do you have any outstanding citizenship concerns? ___________________________

ADVANCED DIRECTIVES/GUARDIANSHIP/LEGAL NEXT OF KIN

- Are you able to make your own healthcare/financial decisions? ☐ Yes ☐ No
- Do you have a legal guardian/representative payee? ☐ Yes ☐ No
- Do you have an Advance Directive? ☐ Yes ☐ No

MEDICAL/ADHERANCE

- What medical condition caused you to need a transplant? ___________________________
- What year did you become aware of your diagnosis? ___________________________
- What other health issues do you have?___________________________
- Do you have a Primary Care Doctor ☐ Yes ☐ No (If yes, name and phone number) ___________________________
- How do you manage your medications? ☐ Memory ☐ List ☐ Pillbox ☐ Caregiver ☐ Other___________________
- Do you have any difficulties paying for, picking up, or taking your medications? ☐ Yes ☐ No
- Have you ever changed the way you take a medication without talking to the doctor? ☐ Yes ☐ No

DIALYSIS

- Are you on dialysis? ☐ Yes ☐ No Date you started dialysis?___________________________
- What type of dialysis do you do? ☐ Hemo ☐ PD ☐ Home Hemo ☐ Nocturnal
- Name and number of your dialysis center___________________________
- What days do you do dialysis: ☐ Mon, Wed, Fri ☐ Tues, Thurs, Sat ☐ 7 days a week ☐ Other___________________________
- What time are you scheduled to get on the dialysis machine? _____________ How long are you on the machine? ______________
- How often do you miss dialysis, get on late, or come off early? ___________________________

FUNCTIONAL ABILITY/PERSONAL CARE

- Do you have any issues with your (check all that apply) ☐Vision ☐ Speech ☐ Hearing
- Do you use ☐Walker ☐ Wheelchair ☐ Cane ☐ Shower Chair ☐ Bedside Commode ☐ Electric Wheelchair/Scooter

- Do you exercise? ☐ Yes ☐ No
- Are you able to complete basic household tasks? ☐ Cook ☐ Clean ☐ Laundry ☐ Yard Work ☐ Grocery Shopping
- Are you able to bathe and groom yourself? ☐ Yes ☐ No

COGNITIVE FUNCTIONING/HEALTH LITERACY

- How do you best learn new information (check all that apply)? ☐ Reading/Personal research ☐ Verbally ☐ Hands-on
- Do you have any history of developmental delays/learning differences/special education? ☐ Yes ☐ No
- Do you have any current or past medical issues that have affected your cognitive functioning? ☐ Yes ☐ No
- Have you noticed any problems with or changes in? ☐ Attention/Concentration ☐ Safety at home ☐ Managing medical regimen

MENTAL HEALTH and DEPRESSION

- Do you have any current or past mental health diagnosis? ☐ Yes ☐ No (check all that apply) ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Bipolar disorder ☐ Anorexia ☐ Bulimia ☐ ADHD ☐ PTSD ☐ Personality Disorder
- Have you ever been abused (check all that apply) ☐ Physically ☐ Emotionally ☐ Sexually
- Have you ever attempted suicide or thought about harming yourself or others? ☐ Yes ☐ No
- Have you ever been hospitalized in a psychiatric hospital? ☐ Yes ☐ No
- Do you currently or have you ever seen a therapist/counselor/psychiatrist? ☐ Yes ☐ No
- Do you currently or have your ever taken medications for mental health issues? ☐ Yes ☐ No

COPING STRATEGIES

- Do you have any current stressors in your life? ☐ Yes ☐ No
- What are your coping strategies for dealing with stressful situations? ______________________________
- Have you had major surgery in the past? ☐ Yes ☐ No
- Did you have any physical, emotional, or financial complications after surgery? ☐ Yes ☐ No

SUBSTANCE USE/ABUSE/DEPENDENCE

- Do you now or have you ever smoked, used chewing tobacco, or vapor/e-cigarettes? ☐ Current ☐ Past
- Do you now or have you ever currently drink alcohol? ☐ Current ☐ Past
- Do you now or have you ever used any illegal drugs? ☐ Current ☐ Past
- Do you now or have you ever abused prescription drugs? ☐ Current ☐ Past
- Have you ever been to an alcohol/drug treatment program? ☐ Yes ☐ No
- Does anyone in your family have a history of drug or alcohol abuse? ☐ Yes ☐ No

LEGAL ISSUES

- Are you now or have you ever been on probation or parole? ☐ Current ☐ Past
- Do you have any current pending legal issues including outstanding warrants? ☐ Yes ☐ No
- Have you had any substance related legal problems? ☐ Yes ☐ No

KNOWLEDGE AND UNDERSTANDING OF TRANSPLANT PROCESS

- Do you know anyone else that has had a transplant? ☐ Yes ☐ No
- Do you understand the risks associated with having a transplant? ☐ Yes ☐ No
- What is your biggest concern about the transplant or transplant process? ______________________________
- Have you ever been transplanted before? ☐ Yes ☐ No
- Have you ever been evaluated for transplant somewhere else? ☐ Yes ☐ No

WILLINGNESS AND DESIRE FOR TRANSPLANT

- Who referred you for transplant evaluation? ☐ Kidney doctor ☐ Dialysis social worker ☐ Primary care doctor ☐ Self ☐ Other
- What do you think would be some benefits to having the transplant? ______________________________
- Why do you want the transplant? ______________________________