ADULT

Transplant Evaluation Patient Packet

MUST be completed and returned within 1 week of receiving this notification.

If you are unable to return within 1 week please call me at 405-271-7498 to advise.

(Postage paid envelope enclosed, or fax to 405-271-4329
Attention: Transplant Social Worker)

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

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

- 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? _____

_____ _____

Patient Signature Date

FINANCIAL WORKSHEET

INSTRUCTIONS: PLEASE READ CAREFULLY AND COMPLETE IN FULL

Please list ALL INCOME coming in to the home (Including side jobs, under the table work, part time jobs, etc.). Please report ALL EXPENSES monthly. If expense is paid quarterly or annually, please divide the amount to come up with a monthly payment. Do not leave off any regular expenses (including tithes, hair, nails casinos, cigarettes, alcohol, etc). For bills that vary month to month please estimate the average monthly expense.

Income-Monthly (Bring home after taxes, ins, etc.)

	Self	Other_____
Employment		
SSI/SSDI		
Social Security Retirement (due to age)		
Retirement (Employment)		
Military Disability		
Child Support		
Food Stamps (Don't count as income)		
Rental Properties		
Royalties		
Annuities		
Income from boarders/family		
Sooner Ride Gas Reimbursement		
Other income		
Total Income:		

Checking/Savings

	Self	Other_____
Checking Acct Balance		
Savings Acct Balance		
401K		
IRA		
Help, Hope, Live		
Other Accounts		
Saved at home (in safe, under mattress)		

Expenses-Monthly

Rent or Mortgage (Please circle)	
Home/Rent Insurance	
Property Tax	
Gas- Natural or Propane (Please circle)	
Water - City or Well (Please circle)	
Electric	
Cable/Home Phone/Internet	
Cell Phone	
Car Insurance	
Car/Boat/RV Payment	
Gasoline for your car	
Groceries/Toiletries (above food stamp amount)	
Medical Bills	
Prescription Meds	
Medical Insurance Premium	
Other Insurance Premiums (Life, etc)	
Credit Card Debt	
Student Loans/Tuition	
Payday Loans	
Bank Loans (other than car/home)	
Furniture/Appliance Payment	
Tax Payments (IRS, State Tax)	
Fines (Tickets, Probation, Parole)	
Child Support	
Other Debt (Tithes, Cigarettes, Casino, Alcohol	
Lawn Service/Housekeeper/Alarm System, etc.)	
Total Debt:	
Total Income:	
Total Remaining:	(+/-)

_____

Patient and/or Support (Sign and Print) **Date**

PLEASE COMPLETE PRIOR TO MDT APPOINTMENT

Employment Benefit Worksheet

ONLY COMPLETE IF EMPLOYED FULL OR PART TIME

Please take to your HR Department to have them assist you in completing this form!

Benefit Type	Employee currently has this benefit YES OR NO	Employee can enroll in this benefit YES OR NO	Open enrollment period	How is time accrued	How is benefit paid	Current Availability (total hours of PTO, etc.)
Paid time off includes vacation and sick						
Paid time off (vacation only)						
Paid time off (sick only)						
FMLA						
Short-term disability						
Long-term disability						
401K or other retirement account						
Health Savings Account						
Paid time off donation program						

Any additional information regarding employee benefits

Transplant Nutrition Assessment Form

Please fill out this questionnaire prior to your appointment. This information will contribute to the development of nutrition therapy based on your needs and current lifestyle habits. Please feel free to include any additional information you feel might be relevant to your current situation.

Personal Information

Name _____ Gender _____ Age _____

Height _____ Dry Weight _____

Medical History

Please provide information about your past medical history. Check all those that may apply.

- ❍ Diabetes
- ❍ Cardiovascular Disease
- ❍ Neurological Condition
- ❍ Other_____
- ❍ Hypertension
- ❍ Cancer
- ❍ Osteoporosis
- ❍ High Cholesterol
- ❍ Kidney Disease
- ❍ Liver Disease

Nutrition Information

Do you have any trouble chewing or swallowing? ❍ Yes ❍ No

Do you have any food allergies or intolerances? ❍ Yes ❍ No

If yes, please list:

_____

Do you take any vitamin, mineral, or herbal supplements? ❍ Yes ❍ No

If yes, please list all such medication:

_____

Please list your current exercise/physical activity patterns:

_____

_____

Do you follow a special diet? ❍ Yes ❍ No

If yes, please describe:

_____

Please remember to bring your **dialysis lab report card** with you to your appointment.

OKLAHOMA TRANSPLANT CENTER

OU Medical Center

Pharmacy Appointment Check List

In preparation for your appointment with the pharmacist, the following immunization record and medication list will be required for you to send to us one week from the date you receive this packet.

IMMUNIZATION RECORDS: Please provide the following vaccine records or work on obtaining the vaccines. Your dialysis center, primary care provider, local health department, and/or any retail pharmacy will be able to help.

PATIENT NAME (Print) _____

Vaccine name	**Date of my vaccine**	**My appointment date for the vaccine (*fill out blank bellow if you did not have the record but have appointment to get vaccine in the future).***
Influenza (Only needed during September to March)	----------	_____
Hepatitis B series	My last HBsAB titer at dialysis_____(ask dialysis nurse to help you) Or fill out the date of your shots #1 shot: _____ #2 shot: _____ #3 shot: _____ #4 shot: _____	Shot #1_____ Shot #2_____ Shot #3_____
Tetanus, diphtheria, and whooping cough (Tdap)	_____(must be within the last 10 years)	_____
Prevnar 13 (conjugated pneumonia vaccine)	_____ (one shot for life). Ask your dialysis nurse for help.	_____
Pneumovax 23 (polysaccharide pneumonia vaccine)	_____ (must be within the last 5 years). Ask your dialysis nurse for help.	_____
Shringrix (Shingles) (only if you are 50 years old or above)	Shot #1_____ Shot #2_____	Shot #1_____ Shot #2_____

_____ _____

Patient Signature Date

PATIENT NAME (Print): _____

MEDICATION RECORD: Please provide a complete list of your current medications including over the counter, herbal supplements, natural products, insulin products, etc... Please include medications that you only takes on an as needed basis as well. (Please use separate sheet of paper if additional space is needed.)

Medication name	Dose	Indications
Metoprolol tartrate 25mg	*2 tabs (50mg) two times a day*	*high blood pressure*

In addition to listing your medication(s) above and submitting this form, ***you are required to bring ALL of your actual medications in their original bottles to your appointment****. Failure to provide any of this information or bring your medications to this appointment may result in delaying your transplant evaluation. Thank you for your cooperation and we are looking forward to meeting with you!*

_____ _____

Patient Signature Date