PEDIATRIC TRANSPLANT PATIENT INFORMATION
(MUST BE COMPLETED AND RETURNED WITHIN ONE WEEK OF RECEIVING)
FORM TO BE COMPLETED BY PARENT OR GUARDIAN

Patients Name: _____ Date of Birth:_____ Age:_____ Date:_____

Address: _____ City_____ State_____ Zip_____

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

EVALUATION TYPE (Check all that apply)

- ☐ Kidney ☐ Liver ☐ New Evaluation ☐ Annual Evaluation

INSURANCE PROVIDER (Check all that apply)

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

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

- Parents/Guardians:_____
  - Is the patient in DHS Custody? ☐ Yes ☐ No
  - Who is primary custodian of the patient? _____
- Siblings: _____
- Grandparents:_____
- Additional Support: _____

LIVING DONOR(S) (Kidney ONLY)

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

TRANSPORTATION

- Does the patient/parent or guardian have a valid license? ☐ Yes ☐ No
- Does the patient/parent or guardian drive? ☐ Yes ☐ No
- Does the patient/parent or guardian have a car? ☐ 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? ☐ Yes ☐ No

RELIGIOUS/SPIRITUAL

- Does the patient or family belong to a religious/spiritual community? (Church, Temple, Mosque, Synagogue) ☐ Yes ☐ No
  (If yes, name of institution.) _____
- Does the patient or family have any personal, religious or spiritual beliefs that would hinder 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 the home ? (Name, age, relationship to you) _____
- Are there any pets? ☐ Yes ☐ No (If yes, what kind(s) and how many?) _____
- Are there any stairs? ☐ Yes ☐ No
- Does the patient have their own room? ☐ Yes ☐ No
- Does the home have working heat and air conditioning? ☐ Yes ☐
- Does the home have running water? ☐ Yes ☐ No
- Does the home have any structural damage? (Leaking windows/roof, mold, etc.) ☐ Yes ☐ No
- Does the home have any assistive devices? (Ramps, grab bars, lift chairs, etc.) ☐ Yes ☐ No

EMPLOYEMENT/RETIREMENT/DISABILITY

- Is patient/parent or guardian employed? ☐ Yes ☐ No
- If yes, name of employer (s)_____
- Full or Part time?_____ Start Date (s):_____
- Do you have access to: ☐ Paid time off ☐ FMLA ☐ Short-term/long term disability

- Does patient/parent or guardian plan to return to work after transplant? ☐ Yes ☐ No
- Do you have any concerns about your job post-transplant? ☐ Yes ☐ No
- How do you plan to cover household expenses while off work? _____

FINANCIAL

- Is parent/guardians current income enough to pay current 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 bills? _____
  _____
- Do you receive food stamps? ☐ Yes ☐ No
- Do you have any payday loans/finance loans? ☐ Yes ☐ No
- Will being off work have an effect on your income? ☐ Yes ☐ No
- How will household expenses be paid if recovery takes longer than anticipated?_____

MILITARY SERVICE

- Have parents/ guardians served in the military? ☐ Yes ☐ No
- Were you involved in active combat? ☐ Yes ☐ No
- Does the patient/parent or guardian use the VA Clinic or Military clinic? ☐ Yes ☐ No ☐ N/A

EDUCATION

- What grade is the patient currently in?_____
- Does the patient have an IEP or 504? ☐ Yes ☐ No
- Can the patient read and write? ☐ Yes ☐ No
- What was the highest-grade parent/guardian completed in school? ☐ High school ☐ GED ☐ Grade____
  ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Trade/VoTech
- Are parents/guardians able to read/write/comprehend English? ☐ Yes ☐ No
- During school were parents/guardians in any special education classes or having any learning disabilities? ☐ Yes ☐ No
- What is parent/guardians native language? _____
- Do you read/write/comprehend in your native language? ☐ Yes ☐ No
- Do you require an interpreter? ☐ Yes ☐ No

CITIZENSHIP

- What is patient's current citizenship status? ☐ Permanent Resident ☐ Naturalized Citizen ☐ Undocumented ☐ Visa
- Was patient born in the United States? ☐ Yes ☐ No If no, what year did patient move to US? _____
- What is parent/guardians current citizenship status? ☐ Permanent Resident ☐ Naturalized Citizen ☐ Undocumented ☐ Visa
- Date of Approval: _____ Date of Expiration: _____
- Do you have any outstanding citizenship concerns? _____

MEDICAL/ADHERANCE

- What is patients medical diagnosis that makes transplant necessary?_____
- What year was patient diagnosed?_____
- Do you know what caused the medical condition? (auto immune, diabetes, high blood pressure, genetics etc?)_____
- Does the patient have any other health issues (diabetes, high blood pressure, high cholesterol, arthritis?) ☐ Yes ☐ No
- Does the patient have a Primary Care Provider (someone they see for colds, etc?) ☐ Yes ☐ No (If yes, name and phone number)_____
- How does patient manage their medications? ☐ Caregiver ☐ Independently ☐ Other_____
- Do you have any difficulties paying for, refilling or picking up medications? ☐ Yes ☐ No
- Has the patient/parent or guardian ever changed the way medication was given without talking to the doctor? ☐ Yes ☐ No

DIALYSIS

- Is patient on dialysis? ☐ Yes ☐ No Date patient started dialysis?_____
- What type of dialysis does the patient do? ☐ Hemo ☐ PD ☐ Home Hemo ☐ Nocturnal
- Name and number of dialysis center_____
- What days does patient do dialysis: ☐ Mon, Wed, Fri ☐ Tues, Thurs, Sat ☐ 7 days a week ☐ Other_____

- What time is patient scheduled to get on the dialysis machine? _____ For how long? _____
- How often does patient miss dialysis, get on late, or come off early? _____
- When/if patient misses what are some of the reasons why? _____
- Does the patient make up missed treatments? ☐ Yes ☐ No

FUNCTIONAL ABILITY/PERSONAL CARE

- Does patient have any issues with your (check all that apply) ☐Vision ☐ Speech ☐ Hearing
- Does patient use ☐Walker ☐ Wheelchair ☐ Cane ☐ Shower Chair ☐ Bedside Commode ☐ Electric Wheelchair/Scooter
- Is patient you able to bathe and groom themselves? ☐ Yes ☐ No
- Please describe patients greatest physical limitation(s) _____

COGNITIVE FUNCTIONING/HEALTH LITERACY

- How does patient learn best (check all that apply)? ☐ Reading/Personal research ☐ Verbally ☐ Hands-on
- Does patient/parent or guardian have any history of developmental delays/learning differences/special education? ☐ Yes ☐ No
- Does patient/parent or guardian have any current or past medical issues that have affected your cognitive functioning? ☐ Yes ☐ No
- Have you noticed any problems with or changes in patients? ☐ Attention/Concentration ☐ Safety at home ☐ Medical Management

MENTAL HEALTH and DEPRESSION

- Does patient 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
- Has patient ever been abused (check all that apply) ☐ Physically ☐ Emotionally ☐ Sexually
- Has patient ever attempted suicide or thought about harming themselves or others? ☐ Yes ☐ No
- Has patient ever been hospitalized in a psychiatric hospital? ☐ Yes ☐ No
- Does patient currently see a therapist/counselor/psychiatrist? ☐ Yes ☐ No
- Has patient ever seen a therapist/counselor? ☐ Yes ☐ No
- Does patient currently take medications for mental health issues? ☐ Yes ☐ No
- Has patient used medications for mental health issues in the past? ☐ Yes ☐ No
- Does parent/guardian have any current or past mental health concerns? ☐ Yes ☐ No (check all that apply) ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Bipolar disorder ☐ Anorexia ☐ Bulimia ☐ ADHD ☐ PTSD ☐ Personality Disorder

COPING STRATEGIES

- Does patient have any current stressors in their life? ☐ Yes ☐ No
- What are patients coping strategies for dealing with stressful situations? _____
- Has patient had major surgery in the past? ☐ Yes ☐ No
- Did patient have any physical or emotional complications after surgery? ☐ Yes ☐ No
- Do parents/guardians have any current stressors in their life? ☐ Yes ☐ No
- What are parents/guardians coping strategies for dealing with stressful situations? _____

SUBSTANCE USE/ABUSE/DEPENDENCE

- Does patient currently (check all that apply) ☐ Use Tobacco ☐ Drink Alcohol ☐ Use Illegal Drugs ☐ Abuse Prescription Drugs
- Do parents/guardians currently (check all that apply) ☐ Use Tobacco ☐ Drink Alcohol ☐ Use Illegal Drugs ☐ Abuse Prescription Drugs
- Has patient/Parent or Guardian ever been to rehab? ☐ Yes ☐ No

LEGAL ISSUES

- Is patient/parent/guardian currently on probation or parole? ☐ Yes ☐ No
- Has patient/parent/guardian ever been on probation or parole? ☐ Yes ☐ No
- Does patient/parent/guardian have any current pending legal issues? ☐ Yes ☐ No
- Does patient/parent/guardian have any active warrants? ☐ Yes ☐ No
- Have patient/parent/guardian 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

- What is patient/parent/guardians biggest concern about the transplant or transplant process? _____
- Does patient/parent/guardian understand the risks associated with having a transplant? ☐ Yes ☐ No
- Has patient ever been transplanted before? ☐ Yes ☐ No
- Has patient ever been evaluated for transplant somewhere else? ☐ Yes ☐ No

WILLINGNESS AND DESIRE FOR TRANSPLANT

- Who referred the patient for transplant evaluation? ☐ Kidney doctor ☐ Dialysis social worker ☐ Primary care doctor ☐Other
- What do you think would be some benefits to having the transplant? _____
- Why does patient/parent/guardian want the transplant? _____