

## QUICK QUOTE FOR LIVER TRANSPLANT

**CLIENT:** NAME \_\_\_\_\_ /  M  F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMT. REQUESTED \$ \_\_\_\_\_ / MAX. ANNUAL PREMIUM \$ \_\_\_\_\_ / TYPE OF INS.  UL  TERM YRS. LVL \_\_\_\_\_

TOBACCO USE  NO  YES, TYPE \_\_\_\_\_ / REPLACEMENT  YES  NO / CURRENT ANN. PREM. \$ \_\_\_\_\_

LAST LIFE INSURANCE APP. YEAR \_\_\_\_\_ COMPANY \_\_\_\_\_ ACTION \_\_\_\_\_

OCCUPATION \_\_\_\_\_ / MARITAL STATUS  SINGLE  MARRIED  WIDOWED  DIVORCED

FAMILY HISTORY –  
AGE, IF STILL LIVING: FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ SIBLING 1 \_\_\_\_\_ SIBLING 2 \_\_\_\_\_ SIBLING 3 \_\_\_\_\_

IF ANY DECEASED, PROVIDE RELATION, AGE AND CAUSE OF DEATH \_\_\_\_\_

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET \_\_\_\_\_

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS \_\_\_\_\_ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS \_\_\_\_\_

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK?  NO  YES, DETAILS \_\_\_\_\_

DATE OF LAST MEDICAL CHECKUP \_\_\_\_\_ RESULTS \_\_\_\_\_

DATE OF LAST RESTING EKG \_\_\_\_\_ RESULTS \_\_\_\_\_

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) \_\_\_\_\_ / ARE YOU TREATED FOR BLOOD PRESSURE?  NO  YES

LAST TOTAL CHOLESTEROL READING AND HDL READING \_\_\_\_\_ / ARE YOU TREATED FOR CHOLESTEROL?  NO  YES

**AGENT:** NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**CPS OFFICE ONLY:** ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

1. PLEASE NOTE DISORDER THAT MADE THE LIVER TRANSPLANT NECESSARY:

- AUTOIMMUNE CIRRHOSIS
- HEMOCHROMATOSIS
- PRIMARY BILIARY CIRRHOSIS
- HEPATITIS
- OTHER, PLEASE DETAIL \_\_\_\_\_

2. DATE OF THE TRANSPLANT \_\_\_\_\_

3. ARE THERE ANY CURRENT SYMPTOMS/COMPLICATIONS?

- NO  YES, DETAILS \_\_\_\_\_

4. GIVE RESULTS OF MOST RECENT LIVER FUNCTION TESTS:

AST(SGOT) \_\_\_\_\_ ALT(SGPT) \_\_\_\_\_

GGT \_\_\_\_\_ ALKALINE PHOSPHATASE \_\_\_\_\_

ALBUMIN \_\_\_\_\_ BILLIRUBIN \_\_\_\_\_

5. PLEASE NOTE ANY OF THE FOLLOWING THAT HAVE OCCURRED (CHECK ALL THAT APPLY):

- FREQUENT INFECTION
- REJECTION EPISODES
- HIGH BLOOD PRESSURE
- CARDIOVASCULAR DISEASE
- TOXICITY FROM TREATMENT
- CANCER
- DISEASE RECURRENCE

6. PLEASE DETAIL ANY CURRENT TREATMENT PRESCRIBED:

\_\_\_\_\_  
\_\_\_\_\_

7. DATE OF THE LAST TIME A PHYSICIAN WAS CONSULTED TO FOLLOW UP ON THE TRANSPLANT:

\_\_\_\_\_

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS TAKEN:

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\_\_\_\_\_