# Transplant Administration Survey

1. Provide the legal name and address of the institution or corporation responsible for the provision of transplant services.

**Name:**

**Street Address:**

**City:**

**State:**  **Zip**:

**Hospital Tax ID Number:**

Chief Executive Officer:

**Telephone:**  **Fax**:

|  |  |  |
| --- | --- | --- |
| 2. Is your institution currently licensed by the State’s regulatory agencies?If not, explain: On what date does your State License expire: | Yes [ ]  | No [ ]  |

|  |  |  |
| --- | --- | --- |
| 3. Are there conditions on the current federal, state, or local licenses, permits, or certifications? | Yes [ ]  | No [ ]  |

If yes, explain:

|  |  |  |
| --- | --- | --- |
| 4. Is your institution affiliated with or the parent corporation of other hospitals / institutions? | Yes [ ]  | No [ ]  |

If yes, what is the name(s) of the affiliated institutions and the nature of the relationship?

**5. Are any pre, transplant episode, or post transplant**

**services (clinic visit, evaluation, major diagnostic testing,** Yes [ ]  No [ ]

**etc.) being provided at the affiliated institutions listed in**

**question 4?**

If yes, please list which affiliate and which type of service.

|  |  |  |
| --- | --- | --- |
| 6. Is your institution accredited by The Joint Commission? | Yes [ ]  | No [ ]  |
| If yes, are there any contingencies on the accreditation? | Yes [ ]  | No [ ]  |

If yes, explain:

|  |  |  |
| --- | --- | --- |
| What was the date of your most recent TJC inspection? |  |  |

## 7. General and Professional Liability Insurance

|  |  |
| --- | --- |
|  | **Coverage** |
| Per Occurrence | Aggregate |
| General Liability |  |  |
| Professional Liability |  |  |

|  |  |  |
| --- | --- | --- |
| 8. Does your facility’s general liability insurance coverage and medical staff professional liability insurance requirements meet state mandates? | Yes [ ]  | No [ ]  |

|  |  |  |
| --- | --- | --- |
| 9. Has your institution ever had or currently has professional or general liability coverage denied, suspended or revoked? | Yes [ ]  | No [ ]  |

If yes, when and for what reason?

## 10. Does your institution’s Medical Staff Bylaws contain a comprehensive process for credentialing and re-credentialing of physicians participating in the organ and blood/marrow transplant programs including primary verification of:

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Licensure | [ ]  | [ ]  |
| Previous Appointments | [ ]  | [ ]  |
| DEA Certificates | [ ]  | [ ]  |
| Previous State Medicare / Medicaid Sanctions | [ ]  | [ ]  |
| The National Practitioner Data Bank | [ ]  | [ ]  |

If no, please attach a copy of the By-Laws related to physician credentialing and re-credentialing.

## 11. Transplant programs available (mark all that apply):

|  | **Type of Transplant** | **Date of First Transplant** |
| --- | --- | --- |
| Adult | Pediatric | Adult | Pediatric |
| Blood and Bone Marrow | Allogeneic Related | [ ]  | [ ]  |  |  |
| Allogeneic Unrelated | [ ]  | [ ]  |  |  |
| Autologous - Marrow | [ ]  | [ ]  |  |  |
| Autologous - Peripheral Blood Stem Cell | [ ]  | [ ]  |  |  |
| Cord Blood | [ ]  | [ ]  |  |  |
| Non-myeloablative  | [ ]  | [ ]  |  |  |
| Heart | Deceased Donor | [ ]  | [ ]  |  |  |
| Domino | [ ]  | [ ]  |  |  |
| Lung | Deceased Donor | [ ]  | [ ]  |  |  |
| Living Donor | [ ]  | [ ]  |  |  |
|  |  |  |  |  |  |
| Intestine | Deceased Donor | [ ]  | [ ]  |  |  |
| Living Donor | [ ]  | [ ]  |  |  |
| Islet Cell | Deceased Donor | [ ]  | [ ]  |  |  |
| Living Donor | [ ]  | [ ]  |  |  |
| Autografts | [ ]  | [ ]  |  |  |
| Kidney | Deceased Donor | [ ]  | [ ]  |  |  |
| Living Donor | [ ]  | [ ]  |  |  |
| Liver | Deceased Donor | [ ]  | [ ]  |  |  |
| Living Donor | [ ]  | [ ]  |  |  |
| Pancreas | Deceased Donor | [ ]  | [ ]  |  |  |
| Living Donor | [ ]  | [ ]  |  |  |
| Combinations | Heart-Lung | [ ]  | [ ]  |  |  |
| Heart-Kidney | [ ]  | [ ]  |  |  |
| Islet-Kidney | [ ]  | [ ]  |  |  |
| Kidney-Pancreas | [ ]  | [ ]  |  |  |
| Liver-Kidney | [ ]  | [ ]  |  |  |
| Liver-Pancreas | [ ]  | [ ]  |  |  |
| Liver-Intestine | [ ]  | [ ]  |  |  |
| Other |  | [ ]  | [ ]  |  |  |

## 12. Name and address of immunology laboratory affiliated with transplant program: (State accreditation organization)

## 13. Name and address of procurement organization that hospital contracts with:

## 14. Facilities and services:

| **Special Inpatient and Outpatient Facilities:** | **Yes** | **No** | **# Beds** |
| --- | --- | --- | --- |
| BMT | [ ]  | [ ]  |  |
| Medical Intensive Care Unit | [ ]  | [ ]  |  |
| Surgical Intensive Care Unit | [ ]  | [ ]  |  |
| Neonatal Intensive Care Unit | [ ]  | [ ]  |  |
| Pediatric Intensive Care Unit | [ ]  | [ ]  |  |
| General Pediatric Unit | [ ]  | [ ]  |  |
| Cardiopulmonary/Thoracic Transplant Unit | [ ]  | [ ]  |  |
| Solid Organ Transplant Unit | [ ]  | [ ]  |  |
| BMT Clinic | [ ]  | [ ]  |  |
| Medical and Surgical Transplant Clinics | [ ]  | [ ]  |  |
| Home Health Transplant Nursing Specialists | [ ]  | [ ]  |  |
| Pediatric cardiology or heart transplant clinic | [ ]  | [ ]  |  |
| **Available 24 hours/day, 7 days/week** | [ ]  | [ ]  |  |
| Anesthesiology | [ ]  | [ ]  |  |
| Pathology | [ ]  | [ ]  |  |
| Blood banking | [ ]  | [ ]  |  |
| Renal dialysis | [ ]  | [ ]  |  |
| Cardiac catheterization and cardiac surgery | [ ]  | [ ]  |  |
| Operating rooms | [ ]  | [ ]  |  |

|  |  |  |
| --- | --- | --- |
| 15. Are accommodations for living arrangements available for patient(s)/companion(s) for both pre and post transplant period? | Yes [ ]  | No [ ]  |

If yes, list and provide information:

## 16. What kind of ongoing training is provided for the transplant staff? What kind of educational services are provided for the community physicians? e.g. conference, workshops, weekly/monthly meetings, etc. Are continuing education credits offered?

**17. Describe any on-going patient safety initiatives.**

## 18. Key contacts

|  | Transplant Administrator or person**completing form** | Transplant Contract Manager |
| --- | --- | --- |
| KidneyPhone/FaxMailing addressEmail |  |  |
| PancreasPhone/FaxMailing addressEmail |  |  |
| LiverPhone/FaxMailing addressEmail |  |  |
| HeartPhone/FaxMailing addressEmail |  |  |
| LungPhone/FaxMailing addressEmail |  |  |
| Marrow/Stem CellPhone/FaxMailing addressEmail |  |  |

I have investigated and certify that the information contained in this survey and all attachments is accurate, complete and true. I understand that submission of this completed survey does not automatically result in continued participation.

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Signature(s) |  |
| Title |  | Date |  |

Bottom of Form