

## **New Patient Information**

- The Blood and Marrow Transplant Outpatient Clinic is located on the 3<sup>rd</sup> floor of the Charles A. Sammons Cancer Center;
- In order to complete the registration process, please arrive 30 minutes prior to your scheduled appointment;
- Bring the new patient paperwork completed to your appointment, if possible;
- Be prepared to stay approximately 1-2 hours for your consultation appointment;
- We allow one guest per patient;
- Due to the immunocompromised nature of our patients, we ask that you wear a mask in the clinic;
- Children are not allowed in BMT clinic;
- We encourage you to ask questions during your consultation, so we suggest bringing a notepad and pen;
- A café and vending machines are located in the building (suites 260 and 270);
- If overnight arrangements are needed, there are two nearby options:
  - Home 2 Suites by Hilton, Dallas Downtown at Baylor Scott & White, 214-765-2690  
Mention medical account #0002736773 to receive a discounted rate.
  - Element by Westin, Dallas Downtown East, 469-399-1049

**If you have additional questions or if you need to cancel your appointment, please contact our new patient coordinator desk at 214-370-1816.**

## Directions and Parking



**Texas Oncology – Blood & Marrow Clinic**  
3410 Worth St. #300, Dallas, TX 75246

### From North Dallas – Hwy. 75

- South on Hwy. 75
- Exit Haskell
- Turn left on Haskell

### From North Dallas – Tollway

- Take the tollway south and continue until the sign for Pearl Street (on the left)
- Take Pearl Street exit (left) and continue through approximately 12 traffic lights
- Turn left at Pacific Street (which will change into Gaston Avenue)
- Pacific Street will change into Gaston Avenue after you go under Central Expressway
- Turn right at Hall Street

### From Dallas I-35

- I-35 to downtown interchange and exit 1-30 East
- Exit Carroll, Peak and Haskell
- Turn left onto Peak

### From South Dallas I-45 and Hwy. 75

- Take I-30 East
- Exit Carroll, Peak and Haskell
- Turn left onto Peak
- Turn left at Worth Street to Valet park
- Self-parking is available in the underground garage accessible from Crutcher Street

### From West Dallas I-30

- I-30 East
- Exit Carroll, Peak and Haskell
- Turn left onto Peak
- Turn left at Worth Street to Valet park
- Self-parking is available in the underground garage accessible from Crutcher Street

### From East Dallas I-30

- I-30 West
- Exit Carroll/Peak
- Turn right onto Peak
- Turn left at Worth Street to Valet park
- Self-parking is available in the underground garage accessible from Crutcher Street



### **P** Self-parking

Patients and visitors may self-park hourly, daily and long term:

- 1 Underground parking – 3400 Crutcher Street
- 2 Garage 4 parking – 3601 Worth Street
- 3 Flat lot parking – 621 N. Hall Street

Cost:

0 to 60 minutes	Free
61 minutes to 2 hours	\$3
2 hours 1 minute to 3 hours	\$4
3 hours 1 minute to 24 hours	\$5
Lost ticket	\$7

Discounted parking:

Passes for unlimited entry/exit to Baylor Scott & White Health garages and lots can be purchased online at

[BSWHealth.com/DallasParking](https://www.bswhealth.com/dallasparking)

Weekly pass	\$25
Monthly pass	\$80

### **V** Valet parking

Valet parking is available at seven locations on campus: Sammons Cancer Center – 3410 Worth Street  
Monday – Friday, 7:00 AM – 5:00 PM

Cost:

Per use	\$8
Per use with a government-issued handicapped tag	\$5

## Supplemental Medical History Questionnaire Form

Today's Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle or Maiden

List names and ages of siblings and indicate if the relationships are (1) full, (2) half, or (3) not biological:

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List names and ages of children and indicate if they are (1) biological or (2) other (adopted, not biological):

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Have you ever been exposed to toxic chemicals/solvents? ☐ Yes ☐ No

If yes, please list: \_\_\_\_\_

Have you ever traveled to a foreign country? ☐ Yes ☐ No

If yes, please list where: \_\_\_\_\_

Have you ever received chemotherapy? ☐ Yes ☐ No

If yes, when was your last dose: \_\_\_\_\_

Have you ever received radiation therapy? ☐ Yes ☐ No

If yes, what part of the body and what facility did you receive care: \_\_\_\_\_

Do you currently have a central venous catheter (i.e, port or PICC)? ☐ Yes ☐ No

Have you ever been exposed to Tuberculosis (TB)? ☐ Yes ☐ No

Have you ever been told you had TB? ☐ Yes ☐ No

Have you ever had a poistive PPD (skin test) for TB? ☐ Yes ☐ No If Yes, date: \_\_\_\_\_

Last Dental Exam (MM/YYYY): \_\_\_\_\_

Do you have animals at home? ☐ Yes ☐ No If yes, what kind of annimals? \_\_\_\_\_

Did you receive immunizations (vaccines) as a child? ☐ Yes ☐ No

## Supplemental Medical History Questionnaire Form

Today's Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle or Maiden

### Transfusion History

Have you ever received a blood product? ☐ Yes ☐ No

If yes, please indicate the number of transfusions and have had:

\_\_\_\_\_ Blood (number of transfusions)

\_\_\_\_\_ Platelets (number of transfusions)

Do you have any religious or cultural beliefs that prohibit receiving blood products? ☐ Yes ☐ No

Have you ever had a reaction to a blood product? ☐ Yes ☐ No

If yes, please describe (include any medications you now receive before getting products):

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Have you ever received injections to boost your blood count? ☐ Yes ☐ No

If yes, were the injections for: ☐ Red Blood Cells ☐ White Blood Cells

### For Women Only

Date of last menstrual period: \_\_\_\_\_ Was it normal? ☐ Yes ☐ No

Have you been through menopause? ☐ Yes ☐ No

Number of pregnancies: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

Last PAP smear: \_\_\_\_\_ Results: \_\_\_\_\_

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I certify that the above information is accurate to the best of my ability.

Signature of Patient/Legally Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if Patient not signing): \_\_\_\_\_

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Texas Oncology Use Only

Date Reviewed: \_\_\_\_\_ Reviewed By: \_\_\_\_\_