



Facility User Profile

As of _____
Date

DIALYSIS FACILITY DEMOGRAPHICS

Facility Name _____

Address _____

City _____ State _____ Zip _____

Primary Contact _____ Title _____

Phone # _____ Fax # _____

Primary contact e-mail address _____
(Resource approvals, new reporting options, notifications for delivery of data, etc.)

Please Check One:

- Freestanding
 Hospital Based
 Nursing Home Based

Medical Director: _____ MD Phone: _____

of Stations _____ # of HD patients _____ # PD patients _____

ESRD NETWORK (circle one)

1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16 17 18

QA CONTACTS (i.e. Director of Nursing, Anemia Manager, Quality Manager, etc.)

Contact _____ Title _____ email _____

Contact _____ Title _____

Contact _____ Title _____

CLINICAL LABORATORY SERVICE PROVIDER (check one)

- ESRD Gambro Spectra Satellite *Other

***VERY IMPORTANT**
Please enter contact name
and phone number.

*Lab Name: _____
*Contact: _____
*Phone #: _____

SOFTWARE UTILIZATION (check all that apply)

Clinical / Billing Info Systems AMI /HII Clinical Vision CyberRen
 di-Proton HyperCare MIQS
 QMS Renalsoft Velos
 Other _____

***VERY IMPORTANT**
Please enter contact name
and phone number.

*Software Contact Name: _____
*Phone #: _____

MEDICATION UTILIZATION (check primary product or indicate % use)

Vitamin D therapy: Calcitriol _____% Hectorol _____% Zemplar _____%

IV Iron therapy: Ferrlecit _____% Venofer _____%

Calcium based Phosphate Binder PhosLo _____% Other _____

Non-calcium based Phosphate Binder Renagel _____% Other _____

Hepatitis B Vaccine Engerix _____% Recombivax