Quality Insights
Renal Network 4

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Network 4 Patient Representative – Recruitment/Referral Form

Name of Dialysis Unit: ________________________________**CCN:** _______________________

Referring Social Worker: __________________________________ **Social worker Phone:** ________________

Social Worker Email: ___________________________ **Social Worker Signature**: _____________________

PLEASE PRINT

Patient Representative Candidate Name: ____

Address: ____

____

Home Phone: _____________________________ **Cell Phone:** _________________________________

Patient Email: (please include – will not be shared) ____

Patient Information:

☐ In Center-Hemodialysis
☐ Peritoneal Dialysis
☐ Home- Hemodialysis
☐ Transplanted (Date of Transplant________)

In Center Dialysis Schedule: M/W/F Time: ___________ T/T/S Time: ___________ Other: ____________________

Is Patient on a transplant list? Yes ☐ No ☐ In process of work-up for list ☐

Patient to read, check each statement below and sign this referral form:

☐ I have read the confidentiality Agreement and with my signature below, I acknowledge the Patient Confidentiality Agreement policies and accept the duty of Patient Representative as appointed.

☐ I authorize Network 4 to utilize my name and email address for specific Patient Representative Program (PRP) communications.

☐ I further authorize QIRN4 to use my name where necessary in listing Patient Representatives in reports to The Centers for Medicare and Medicaid Services (CMS).

Signature of Candidate: ___________________________________ Date: ________________________

Fax completed form to QIRN4 Office: 610.783.0374