

Peer Mentoring Program





Form Instructions

The dialysis facility must complete this form for each patient who wants to serve as a peer mentor or mentee. Please <u>fax</u> the completed form to your respective ESRD Network to 972-503-3219 to the attention of Debbie O'Daniel.

Facility Information						
CMS Certification Number (CCN)						
Facility Name						
ESRD Network						
First Name			Last Name			
Title	 Facility Administrator Nephrologist Nurse 	□ Socia □ Techr □ Rece		☐ Other <i>,</i> blease specify:		
Phone Number			Email Address	xyz@gmail.c	com	

Peer Mentoring Referral						
Referral Date	Unique Patient Identifier (UPI)					
Patient's First Name		Patient's Last Name				
Phone Number		Type of Phone Line	🗆 Cell 🛛 🗆 Land Line			
Email Address						
Age		5–44 5–54	□ 55–64 □ 65+			
Current Treatment Type	 □ In-center hemodialysis □ Peritoneal dialy □ Home hemodialysis □ Peritoneal dialy □ Transplant 					
Preferred Language	English Spanish	🗆 Other, please sp	ecify:			
Communication Preferences for Mentor Program	 In-person (when/where available) Telephone Email Facetime 	 Google Duo (app that allows face-to-face calling between Android and iOS) Google Hangout Messenger (Facebook or WhatsApp) Skype Zoom 				
Facility Mentoring	Mentor	🗆 Mentee				
Topics of Interest	□ New to Dialysis □ H	lome Dialysis	Transplant			

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