

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS Check one: Initial Re-entitlement Supplemental

1. Name (Last, First, Middle Initial) _____

2. Medicare Claim Number	3. Social Security Number	4. Date of Birth MM / DD / YYYY
5. Patient Mailing Address (Include City, State and Zip)		6. Phone Number ()

7. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Ethnicity <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino (Complete Item 9)	9. Country/Area of Origin or Ancestry
---	---	---------------------------------------

10. Race (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander* Print Name of Enrolled/Principal Tribe _____ *complete Item 9	11. Is patient applying for ESRD Medicare coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

12. Current Medical Coverage (Check all that apply) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Employer Group Health Insurance <input type="checkbox"/> DVA <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Other <input type="checkbox"/> None	13. Height INCHES _____ OR CENTIMETERS _____	14. Dry Weight POUNDS _____ OR KILOGRAMS _____	15. Primary Cause of Renal Failure (Use code from back of form)
--	--	--	---

16. Employment Status (6 mos prior and current status) <table style="width: 100%;"> <tr> <td style="text-align: center; vertical-align: middle;">Prior</td> <td style="text-align: center; vertical-align: middle;">Current</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Unemployed</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Employed Full Time</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Employed Part Time</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Homemaker</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Retired due to Age/Preference</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Retired (Disability)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Medical Leave of Absence</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Student</td> </tr> </table>	Prior	Current		<input type="checkbox"/>	<input type="checkbox"/>	Unemployed	<input type="checkbox"/>	<input type="checkbox"/>	Employed Full Time	<input type="checkbox"/>	<input type="checkbox"/>	Employed Part Time	<input type="checkbox"/>	<input type="checkbox"/>	Homemaker	<input type="checkbox"/>	<input type="checkbox"/>	Retired due to Age/Preference	<input type="checkbox"/>	<input type="checkbox"/>	Retired (Disability)	<input type="checkbox"/>	<input type="checkbox"/>	Medical Leave of Absence	<input type="checkbox"/>	<input type="checkbox"/>	Student	17. Co-Morbid Conditions (Check all that apply currently and/or during last 10 years)*See instructions <table style="width: 100%;"> <tr> <td style="width: 33%;">a. <input type="checkbox"/> Congestive heart failure</td> <td style="width: 33%;">n. <input type="checkbox"/> Malignant neoplasm, Cancer</td> </tr> <tr> <td>b. <input type="checkbox"/> Atherosclerotic heart disease ASHD</td> <td>o. <input type="checkbox"/> Toxic nephropathy</td> </tr> <tr> <td>c. <input type="checkbox"/> Other cardiac disease</td> <td>p. <input type="checkbox"/> Alcohol dependence</td> </tr> <tr> <td>d. <input type="checkbox"/> Cerebrovascular disease, CVA, TIA*</td> <td>q. <input type="checkbox"/> Drug dependence*</td> </tr> <tr> <td>e. <input type="checkbox"/> Peripheral vascular disease*</td> <td>r. <input type="checkbox"/> Inability to ambulate</td> </tr> <tr> <td>f. <input type="checkbox"/> History of hypertension</td> <td>s. <input type="checkbox"/> Inability to transfer</td> </tr> <tr> <td>g. <input type="checkbox"/> Amputation</td> <td>t. <input type="checkbox"/> Needs assistance with daily activities</td> </tr> <tr> <td>h. <input type="checkbox"/> Diabetes, currently on insulin</td> <td>u. <input type="checkbox"/> Institutionalized</td> </tr> <tr> <td>i. <input type="checkbox"/> Diabetes, on oral medications</td> <td><input type="checkbox"/> 1. Assisted Living</td> </tr> <tr> <td>j. <input type="checkbox"/> Diabetes, without medications</td> <td><input type="checkbox"/> 2. Nursing Home</td> </tr> <tr> <td>k. <input type="checkbox"/> Diabetic retinopathy</td> <td><input type="checkbox"/> 3. Other Institution</td> </tr> <tr> <td>l. <input type="checkbox"/> Chronic obstructive pulmonary disease</td> <td>v. <input type="checkbox"/> Non-renal congenital abnormality</td> </tr> <tr> <td>m. <input type="checkbox"/> Tobacco use (current smoker)</td> <td>w. <input type="checkbox"/> None</td> </tr> </table>		a. <input type="checkbox"/> Congestive heart failure	n. <input type="checkbox"/> Malignant neoplasm, Cancer	b. <input type="checkbox"/> Atherosclerotic heart disease ASHD	o. <input type="checkbox"/> Toxic nephropathy	c. <input type="checkbox"/> Other cardiac disease	p. <input type="checkbox"/> Alcohol dependence	d. <input type="checkbox"/> Cerebrovascular disease, CVA, TIA*	q. <input type="checkbox"/> Drug dependence*	e. <input type="checkbox"/> Peripheral vascular disease*	r. <input type="checkbox"/> Inability to ambulate	f. <input type="checkbox"/> History of hypertension	s. <input type="checkbox"/> Inability to transfer	g. <input type="checkbox"/> Amputation	t. <input type="checkbox"/> Needs assistance with daily activities	h. <input type="checkbox"/> Diabetes, currently on insulin	u. <input type="checkbox"/> Institutionalized	i. <input type="checkbox"/> Diabetes, on oral medications	<input type="checkbox"/> 1. Assisted Living	j. <input type="checkbox"/> Diabetes, without medications	<input type="checkbox"/> 2. Nursing Home	k. <input type="checkbox"/> Diabetic retinopathy	<input type="checkbox"/> 3. Other Institution	l. <input type="checkbox"/> Chronic obstructive pulmonary disease	v. <input type="checkbox"/> Non-renal congenital abnormality	m. <input type="checkbox"/> Tobacco use (current smoker)	w. <input type="checkbox"/> None
Prior	Current																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Unemployed																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Employed Full Time																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Employed Part Time																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Homemaker																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Retired due to Age/Preference																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Retired (Disability)																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Medical Leave of Absence																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Student																																																					
a. <input type="checkbox"/> Congestive heart failure	n. <input type="checkbox"/> Malignant neoplasm, Cancer																																																						
b. <input type="checkbox"/> Atherosclerotic heart disease ASHD	o. <input type="checkbox"/> Toxic nephropathy																																																						
c. <input type="checkbox"/> Other cardiac disease	p. <input type="checkbox"/> Alcohol dependence																																																						
d. <input type="checkbox"/> Cerebrovascular disease, CVA, TIA*	q. <input type="checkbox"/> Drug dependence*																																																						
e. <input type="checkbox"/> Peripheral vascular disease*	r. <input type="checkbox"/> Inability to ambulate																																																						
f. <input type="checkbox"/> History of hypertension	s. <input type="checkbox"/> Inability to transfer																																																						
g. <input type="checkbox"/> Amputation	t. <input type="checkbox"/> Needs assistance with daily activities																																																						
h. <input type="checkbox"/> Diabetes, currently on insulin	u. <input type="checkbox"/> Institutionalized																																																						
i. <input type="checkbox"/> Diabetes, on oral medications	<input type="checkbox"/> 1. Assisted Living																																																						
j. <input type="checkbox"/> Diabetes, without medications	<input type="checkbox"/> 2. Nursing Home																																																						
k. <input type="checkbox"/> Diabetic retinopathy	<input type="checkbox"/> 3. Other Institution																																																						
l. <input type="checkbox"/> Chronic obstructive pulmonary disease	v. <input type="checkbox"/> Non-renal congenital abnormality																																																						
m. <input type="checkbox"/> Tobacco use (current smoker)	w. <input type="checkbox"/> None																																																						

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	If Yes, answer: <input type="checkbox"/> 6-12 months <input type="checkbox"/> >12 months
b. Was patient under care of a nephrologist?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	If Yes, answer: <input type="checkbox"/> 6-12 months <input type="checkbox"/> >12 months
c. Was patient under care of kidney dietitian?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	If Yes, answer: <input type="checkbox"/> 6-12 months <input type="checkbox"/> >12 months
d. What access was used on first outpatient dialysis: If not AVF, then: Is maturing AVF present? Is maturing graft present?	AVF <input type="checkbox"/> Graft <input type="checkbox"/> Catheter <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Other

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)	_____	____/____/____	d. HbA1c	_____ %	____/____/____
a.2. Serum Albumin Lower Limit	_____	____/____/____	e. Lipid Profile TC	_____	____/____/____
a.3. Lab Method Used (BCG or BCP)	_____	____/____/____	LDL	_____	____/____/____
b. Serum Creatinine (mg/dl)	_____	____/____/____	HDL	_____	____/____/____
c. Hemoglobin (g/dl)	_____	____/____/____	TG	_____	____/____/____

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility	21. Medicare Provider Number (for item 20)
22. Primary Dialysis Setting <input type="checkbox"/> Home <input type="checkbox"/> Dialysis Facility/Center <input type="checkbox"/> SNF/Long Term Care Facility	23. Primary Type of Dialysis <input type="checkbox"/> Hemodialysis (Sessions per week ____/hours per session ____) <input type="checkbox"/> CAPD <input type="checkbox"/> CCPD <input type="checkbox"/> Other
24. Date Regular Chronic Dialysis Began MM / DD / YYYY	25. Date Patient Started Chronic Dialysis at Current Facility MM / DD / YYYY
26. Has patient been informed of kidney transplant options? <input type="checkbox"/> Yes <input type="checkbox"/> No	27. If patient NOT informed of transplant options, please check all that apply: <input type="checkbox"/> Medically unfit <input type="checkbox"/> Patient declines information <input type="checkbox"/> Unsuitable due to age <input type="checkbox"/> Patient has not been assessed <input type="checkbox"/> Psychologically unfit <input type="checkbox"/> Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

28. Date of Transplant MM / DD / YYYY	29. Name of Transplant Hospital	30. Medicare Provider Number for Item 29
Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.		
31. Enter Date MM / DD / YYYY	32. Name of Preparation Hospital	33. Medicare Provider number for Item 32
34. Current Status of Transplant (if functioning, skip items 36 and 37) <input type="checkbox"/> Functioning <input type="checkbox"/> Non-Functioning	35. Type of Donor: <input type="checkbox"/> Deceased <input type="checkbox"/> Living Related <input type="checkbox"/> Living Unrelated	
36. If Non-Functioning, Date of Return to Regular Dialysis MM / DD / YYYY	37. Current Dialysis Treatment Site <input type="checkbox"/> Home <input type="checkbox"/> Dialysis Facility/Center <input type="checkbox"/> SNF/Long Term Care Facility	

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

38. Name of Training Provider	39. Medicare Provider Number of Training Provider (for Item 38)	
40. Date Training Began MM / DD / YYYY	41. Type of Training <input type="checkbox"/> Hemodialysis a. <input type="checkbox"/> Home b. <input type="checkbox"/> In Center <input type="checkbox"/> CAPD <input type="checkbox"/> CCPD <input type="checkbox"/> Other	
42. This Patient is Expected to Complete (or has completed) Training and will Self-dialyze on a Regular Basis. <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Date When Patient Completed, or is Expected to Complete, Training MM / DD / YYYY	

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

44. Printed Name and Signature of Physician personally familiar with the patient's training a.) Printed Name b.) Signature c.) Date MM / DD / YYYY	45. UPIN of Physician in Item 44
---	----------------------------------

E. PHYSICIAN IDENTIFICATION

46. Attending Physician (Print)	47. Physician's Phone No. ()	48. UPIN of Physician in Item 46
---------------------------------	-------------------------------------	----------------------------------

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

49. Attending Physician's Signature of Attestation (Same as Item 46)	50. Date MM / DD / YYYY
51. Physician Recertification Signature	52. Date MM / DD / YYYY
53. Remarks	

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

54. Signature of Patient (Signature by mark must be witnessed.)	55. Date MM / DD / YYYY
---	----------------------------

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the *Federal Register* notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

LIST OF PRIMARY CAUSES OF END STAGE RENAL DISEASE

Item 15. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-9-CM code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary. **Code effective as of September 2003.**

DIABETES

- 25040 Diabetes with renal manifestations Type 2
- 25041 Diabetes with renal manifestations Type 1

GLOMERULONEPHRITIS

- 5829 Glomerulonephritis (GN)
(histologically not examined)
- 5821 Focal glomerulosclerosis, focal sclerosing GN
- 5831 Membranous nephropathy
- 58321 Membranoproliferative GN type 1, diffuse MPGN
- 58322 Dense deposit disease, MPGN type 2
- 58381 IgA nephropathy, Berger's disease
(proven by immunofluorescence)
- 58382 IgM nephropathy (proven by immunofluorescence)
- 5834 With lesion of rapidly progressive GN
- 5800 Post infectious GN, SBE
- 5820 Other proliferative GN

SECONDARY GN/VASCULITIS

- 7100 Lupus erythematosus, (SLE nephritis)
- 2870 Henoch-Schonlein syndrome
- 7101 Scleroderma
- 28311 Hemolytic uremic syndrome
- 4460 Polyarteritis
- 4464 Wegener's granulomatosis
- 58392 Nephropathy due to heroin abuse and related drugs
- 44620 Other Vasculitis and its derivatives
- 44621 Goodpasture's syndrome
- 58391 Secondary GN, other

INTERSTITIAL NEPHRITIS/PYELONEPHRITIS

- 9659 Analgesic abuse
- 5830 Radiation nephritis
- 9849 Lead nephropathy
- 5909 Nephropathy caused by other agents
- 27410 Gouty nephropathy
- 5920 Nephrolithiasis
- 5996 Acquired obstructive uropathy
- 5900 Chronic pyelonephritis, reflux nephropathy
- 58389 Chronic interstitial nephritis
- 58089 Acute interstitial nephritis
- 5929 Urolithiasis
- 27549 Other disorders of calcium metabolism

HYPERTENSION/LARGE VESSEL DISEASE

- 40391 Unspecified with renal failure
- 4401 Renal artery stenosis
- 59381 Renal artery occlusion
- 59383 Cholesterol emboli, renal emboli

CYSTIC/HEREDITARY/CONGENITAL DISEASES

- 75313 Polycystic kidneys, adult type (dominant)
- 75314 Polycystic, infantile (recessive)
- 75316 Medullary cystic disease, including nephronophthisis
- 7595 Tuberous sclerosis
- 7598 Hereditary nephritis, Alport's syndrome
- 2700 Cystinosis
- 2718 Primary oxalosis
- 2727 Fabry's disease
- 7533 Congenital nephrotic syndrome
- 5839 Drash syndrome, mesangial sclerosis
- 75321 Congenital obstruction of ureteropelvic junction
- 75322 Congenital obstruction of ureterovesical junction
- 75329 Other Congenital obstructive uropathy
- 7530 Renal hypoplasia, dysplasia, oligonephronia
- 75671 Prune belly syndrome
- 75989 Other (congenital malformation syndromes)

NEOPLASMS/TUMORS

- 1890 Renal tumor (malignant)
- 1899 Urinary tract tumor (malignant)
- 2230 Renal tumor (benign)
- 2239 Urinary tract tumor (benign)
- 23951 Renal tumor (unspecified)
- 23952 Urinary tract tumor (unspecified)
- 20280 Lymphoma of kidneys
- 20300 Multiple myeloma
- 20308 Other immuno proliferative neoplasms
(including light chain nephropathy)
- 2773 Amyloidosis
- 99680 Complications of transplanted organ unspecified
- 99681 Complications of transplanted kidney
- 99682 Complications of transplanted liver
- 99683 Complications of transplanted heart
- 99684 Complications of transplanted lung
- 99685 Complications of transplanted bone marrow
- 99686 Complications of transplanted pancreas
- 99687 Complications of transplanted intestine
- 99689 Complications of other specified transplanted organ

MISCELLANEOUS CONDITIONS

- 28260 Sickle cell disease/anemia
- 28269 Sickle cell trait and other sickle cell (HbS/Hb other)
- 64620 Post partum renal failure
- 042 AIDS nephropathy
- 8660 Traumatic or surgical loss of kidney(s)
- 5724 Hepatorenal syndrome
- 5836 Tubular necrosis (no recovery)
- 59389 Other renal disorders
- 7999 Etiology uncertain

ESRD DEATH NOTIFICATION

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

1. Patient's Last Name	First	MI	2. Medicare Claim Number
3. Patient's Sex a. <input type="checkbox"/> Male b. <input type="checkbox"/> Female	4. Date of Birth ____ / ____ / ____ Month Day Year		5. Social Security Number
6. Patient's State of Residence	7. Place of Death a. <input type="checkbox"/> Hospital c. <input type="checkbox"/> Home e. <input type="checkbox"/> Other b. <input type="checkbox"/> Dialysis Unit d. <input type="checkbox"/> Nursing Home		8. Date of Death ____ / ____ / ____ Month Day Year
9. Modality at Time of Death a. <input type="checkbox"/> Incenter Hemodialysis b. <input type="checkbox"/> Home Hemodialysis c. <input type="checkbox"/> CAPD d. <input type="checkbox"/> CCPD e. <input type="checkbox"/> Transplant f. <input type="checkbox"/> Other			
10. Provider Name and Address (Street)			11. Provider Number

Provider Address (City/State)

12. Causes of Death (enter codes from list on back of form)

- a. Primary Cause _ _ _
- b. Were there secondary causes?
 No
 Yes, specify: _ _ _ _ _ _ _ _ _ _
- c. If cause is other (98) please specify: _____

<p>13. Renal replacement therapy discontinued prior to death: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, check one of the following:</p> <p>a. <input type="checkbox"/> Following HD and/or PD access failure</p> <p>b. <input type="checkbox"/> Following transplant failure</p> <p>c. <input type="checkbox"/> Following chronic failure to thrive</p> <p>d. <input type="checkbox"/> Following acute medical complication</p> <p>e. <input type="checkbox"/> Other</p> <p>f. Date of last dialysis treatment ____ / ____ / ____ Month Day Year</p>	<p>14. Was discontinuation of renal replacement therapy after patient/family request to stop dialysis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable</p>
--	--

<p>15. If deceased ever received a transplant:</p> <p>a. Date of most recent transplant ____ / ____ / ____ <input type="checkbox"/> Unknown Month Day Year</p> <p>b. Type of transplant received <input type="checkbox"/> Living Related <input type="checkbox"/> Living Unrelated <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown</p> <p>c. Was graft functioning (patient not on dialysis) at time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>d. Did transplant patient resume chronic maintenance dialysis prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>16. Was patient receiving Hospice care prior to death?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>
--	--

17. Name of Physician (Please print complete name)	18. Signature of Person Completing This Form	Date
--	--	------

This report is required by law (42, U.S.C. 426; 20 CFR 405, Section 2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 U.S.C. 5520; 45 CFR Part 5a).

**ESRD DEATH NOTIFICATION FORM
LIST OF CAUSES**

CARDIAC

- 23 Myocardial infarction, acute
- 25 Pericarditis, incl. Cardiac tamponade
- 26 Atherosclerotic heart disease
- 27 Cardiomyopathy
- 28 Cardiac arrhythmia
- 29 Cardiac arrest, cause unknown
- 30 Valvular heart disease
- 31 Pulmonary edema due to exogenous fluid
- 32 Congestive Heart Failure

VASCULAR

- 35 Pulmonary embolus
- 36 Cerebrovascular accident including intracranial hemorrhage
- 37 Ischemic brain damage/Anoxic encephalopathy
- 38 Hemorrhage from transplant site
- 39 Hemorrhage from vascular access
- 40 Hemorrhage from dialysis circuit
- 41 Hemorrhage from ruptured vascular aneurysm
- 42 Hemorrhage from surgery (not 38, 39, or 41)
- 43 Other hemorrhage (not 38-42, 72)
- 44 Mesenteric infarction/ischemic bowel

INFECTION

- 33 Septicemia due to internal vascular access
- 34 Septicemia due to vascular access catheter
- 45 Peritoneal access infectious complication, bacterial
- 46 Peritoneal access infectious complication, fungal
- 47 Peritonitis (complication of peritoneal dialysis)
- 48 Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)
- 51 Septicemia due to peripheral vascular disease, gangrene
- 52 Septicemia, other
- 61 Cardiac infection (endocarditis)
- 62 Pulmonary infection (pneumonia, influenza)
- 63 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular disease, gallbladder)
- 70 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

LIVER DISEASE

- 64 Hepatitis B
- 71 Hepatitis C
- 65 Other viral hepatitis
- 66 Liver-drug toxicity
- 67 Cirrhosis
- 68 Polycystic liver disease
- 69 Liver failure, cause unknown or other

GASTRO-INTESTINAL

- 72 Gastro-intestinal hemorrhage
- 73 Pancreatitis
- 75 Perforation of peptic ulcer
- 76 Perforation of bowel (not 75)

METABOLIC

- 24 Hyperkalemia
- 77 Hypokalemia
- 78 Hyponatremia
- 79 Hyponatremia
- 100 Hypoglycemia
- 101 Hyperglycemia
- 102 Diabetic coma
- 95 Acidosis

ENDOCRINE

- 96 Adrenal insufficiency
- 97 Hypothyroidism
- 103 Hyperthyroidism

OTHER

- 80 Bone marrow depression
- 81 Cachexia/failure to thrive
- 82 Malignant disease, patient ever on Immunosuppressive therapy
- 83 Malignant disease (not 82)
- 84 Dementia, incl. dialysis dementia, Alzheimer's
- 85 Seizures
- 87 Chronic obstructive lung disease (COPD)
- 88 Complications of surgery
- 89 Air embolism
- 104 Withdrawal from dialysis/uremia
- 90 Accident related to treatment
- 91 Accident unrelated to treatment
- 92 Suicide
- 93 Drug overdose (street drugs)
- 94 Drug overdose (not 92 or 93)
- 98 Other cause of death
- 99 Unknown

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0448. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM ESRD FACILITY SURVEY (DIALYSIS UNITS ONLY)	FOR THE PERIOD
Facility Physical Address _____ <i>(If different than mailing address) Suite/Room Street City State/Zip Code</i>	
Number of Dialysis Stations: _____ Facility Telephone: (_____)	
Facility Ownership Type: <input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit	
Facility Local/National Affiliation/Chain Information _____ <i>(i.e. Gambro, etc.)</i>	
Types of dialysis services offered: <input type="checkbox"/> Incenter Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis Training	
Does your facility offer a dialysis shift that starts at 5:00 p.m. or later? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DIALYSIS PATIENTS AND TREATMENTS

DIALYSIS PATIENTS

Patients Receiving Care Beginning of Survey Period			Additions During Survey Period				Losses During Survey Period					
Incenter	Home	Total Fields 01 thru 02	Started for first time ever	Restarted	Transferred from other dialysis unit	Returned after transplantation	Deaths	Recovered kidney function	Received trans-plant	Transferred to other dialysis unit	Dis-continued dialysis	Other (LTFU)
01	02	03	04A 04B	05A 05B	06A 06B	07A 07B	08A 08B	09A 09B	10A 10B	11A 11B	12A 12B	13A 13B

Patients Receiving Care at End of Survey Period												Total Patients Fields 20 and 25
Incenter Dialysis		Self-Dialysis Training				Total Incenter Dialysis	Home Dialysis				Total Home Dialysis	
Hemo-Dialysis	Other	Hemo-Dialysis	CAPD	CCPD	Other	Fields 14 thru 19	Hemo-Dialysis	CAPD	CCPD	Other	Fields 21 thru 24	
14	15	16	17	18	19	20	21	22	23	24	25	26

Patient Eligibility Status End of Survey Period		
Currently enrolled in Medicare	Medicare application pending	Non-Medicare
27	28	29

Hemodialysis Patients Dialyzing More Than 4 Times Per Week		
Setting	Day	Nocturnal
Incenter		
Home		
	30A 30B	31A 31B

Vocational Rehabilitation			
Patients aged 18 through 54	Patients receiving services from Voc Rehab	Patients Employed full-time or part-time	Patients attending school full-time or part-time
32	33	34	35

TREATMENT AND STAFFING

Incenter Dialysis Treatments (Include Training Treatments)	
Hemodialysis	Other
36	37

Staffing				
Position	Number of Staff		Number of Open Pos.	
	Full Time	Part Time	Full Time	Part Time
a. RNs				
b. LPN/LVNs				
c. PCTs				
d. APNs				
e. Dietitians				
f. Social Workers				
	38	39	40	41

COMPLETED BY (Name)	DATE	TITLE	TELEPHONE NO.
---------------------	------	-------	---------------

REMARKS REGARDING INFORMATION PROVIDED ON THIS SURVEY SHOULD BE ENTERED ON THE LAST PAGE OF THE SURVEY

This report is required by law (42 USC 426; 42 CFR 405.2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 USC 5520; 45 CFR, Part 5a).

**END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM
ESRD FACILITY SURVEY (TRANSPLANT CENTERS ONLY)**

FOR THE PERIOD

KIDNEY TRANSPLANTS PERFORMED

**PATIENTS TRANSPLANTED
AND DONOR TYPE**

**TO BE COMPLETED BY
KIDNEY TRANSPLANT CENTERS ONLY**

Patients who received transplant at this facility			

42

Eligibility Status of Patients Transplanted at this Facility During the Survey Period			
Currently enrolled in Medicare	Medicare application pending	Non-Medicare	
		U.S. Res.	Other

43

44

45

46

Transplant Procedures Performed at This Facility			
Living Related Donor	Living Unrelated Donor	Deceased Donor	Total Fields 47 thru 49

47

48

49

50

Patients Awaiting Transplant	
Dialysis	Nondialysis

51

52

REMARKS/COMMENTS

COMPLETED BY (Name)	DATE	TITLE	TELEPHONE NO.
---------------------	------	-------	---------------

This report is required by law (42 USC 426; 42 CFR 405.2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 USC 5520; 45 CFR, Part 5a).