

The Florida ESRD Network (Network 7) wants to hear from you!  
**In-Center Hemodialysis Patient Education Needs Assessment**  
Please complete and return this Needs Assessment to your dialysis facility.

What language are you most comfortable understanding/reading?	
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> French <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other. Specify: _____	
1. Do you know how to file a grievance (complaint)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your facility explained to you situations that could result in your being involuntarily discharged (forced to leave the facility) from the dialysis unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you aware of the Dialysis Facility Compare website? ( <a href="http://www.medicare.gov/dialysisfacilitycompare">www.medicare.gov/dialysisfacilitycompare</a> )	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. What is your preferred way of receiving health education? (Check up to three.)	<input type="checkbox"/> Video <input type="checkbox"/> Internet health newsletters <input type="checkbox"/> Written <input type="checkbox"/> Internet health websites <input type="checkbox"/> Email information from healthcare providers <input type="checkbox"/> Face-to-face <input type="checkbox"/> Other. Specify: _____
5. How do you get most of your health education? (Check all that apply.)	<input type="checkbox"/> Network 7 Patient Newsletter <input type="checkbox"/> Other newsletters <input type="checkbox"/> Support group <input type="checkbox"/> Other patients <input type="checkbox"/> Dialysis staff <input type="checkbox"/> My doctor <input type="checkbox"/> Internet <input type="checkbox"/> American Association of Kidney Patients <input type="checkbox"/> Other. Specify: _____
6. In the last year have you been invited to your Plan of Care meeting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6a. If yes, did you attend?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6b. If you attended your Plan of Care meeting, do you think your opinions were heard?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you think being part of your Plan of Care meeting is important?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Please tell us what kind of Dialysis Patient/Family Support Groups you have ever attended or are currently attending. (Check all that apply.)	<input type="checkbox"/> I have never attended a support group. <input type="checkbox"/> Internet support groups/chat rooms <input type="checkbox"/> Facility support groups during regular business or treatment hours <input type="checkbox"/> An off-site group meeting after regular business/treatment hours <input type="checkbox"/> Event oriented support groups
9. How likely would you be to start or promote a support group for your facility if information and materials were provided for you?	<input type="checkbox"/> Extremely Likely <input type="checkbox"/> Likely <input type="checkbox"/> Somewhat Likely <input type="checkbox"/> Unlikely
10. If Network 7 were to contact you about participating in a patient-family council, how likely would you be to participate?	<input type="checkbox"/> Extremely Likely <input type="checkbox"/> Likely <input type="checkbox"/> Somewhat Likely <input type="checkbox"/> Unlikely
11. Do you know what each of your medications is for?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>12. How often do you exercise?</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Unable to exercise
<b>13. How often do you gain 3 or more kilograms (6.6 pounds) between treatments?</b>	<input type="checkbox"/> Occasionally <input type="checkbox"/> Every treatment <input type="checkbox"/> Only after the weekend <input type="checkbox"/> Never
<b>14. Do you follow your renal diet?</b>	<input type="checkbox"/> Always <input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely
<b>15. How important to you is being able to travel?</b>	<input type="checkbox"/> Extremely important <input type="checkbox"/> Very important <input type="checkbox"/> Important <input type="checkbox"/> Somewhat important <input type="checkbox"/> Not important
<b>16. I have a:</b>	<input type="checkbox"/> Catheter <input type="checkbox"/> AV fistula <input type="checkbox"/> Graft
<b>16a. If you have had a catheter for greater than 90 days, have you been approached by staff for alternative access placement?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>16b. If you have been approached by staff for alternative access placement, have you been referred to a surgeon?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>16c. If you have been approached to have access placement, and declined, what are your reasons for declining? (Check all that apply.)</b>	<input type="checkbox"/> I don't think it is important. <input type="checkbox"/> I am afraid of needles. <input type="checkbox"/> I am concerned about how it will look. <input type="checkbox"/> I don't know enough to make a good decision. <input type="checkbox"/> I am afraid of the side effects of placement. <input type="checkbox"/> I could not get an appointment scheduled with the surgeon. <input type="checkbox"/> I did not have medical insurance in the first 90 days. <input type="checkbox"/> I had two or more accesses placed and they did not work.
<b>17. Have you been educated about any of the following infection control practices in the dialysis facility? (Check all that apply.)</b>	<input type="checkbox"/> Hand-washing or alcohol gel <input type="checkbox"/> Gloves <input type="checkbox"/> Masks (catheters or when sick) <input type="checkbox"/> Washing access prior to treatment (AVF/AVG) <input type="checkbox"/> None of these
<b>18. Do you have a habit of shortening your treatment?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>19. Do you currently come to every scheduled treatment?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>20. Have you considered Home Dialysis Therapy (Home Hemodialysis or Peritoneal Dialysis)?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>21. My facility provided education/information on the following treatment options: (Check all that apply.)</b>	<input type="checkbox"/> Continuous Ambulatory Peritoneal Dialysis <input type="checkbox"/> Continuous Cycling Peritoneal Dialysis <input type="checkbox"/> Conventional Home Hemodialysis <input type="checkbox"/> Nocturnal Hemodialysis <input type="checkbox"/> No Therapy <input type="checkbox"/> Kidney Transplant <input type="checkbox"/> None of these <input type="checkbox"/> Short Daily Hemodialysis

**Thank you for Participating!**