



Hospital Profile

(Please print this form, fill-in & return by fax to 484-361-6705. Thank you.)

General Information:

Date: _____

Hospital Name: _____

Address: _____

Director of Pharmacy: _____ Phone Number: _____

Number Licensed beds: _____ Average Census: _____ Current Census: _____

Hospital Specialty (If any): _____

Pharmacy hours of operation on weekdays: _____

Pharmacy hours of operation on weekends: _____

Pharmacy hours of operation on holidays: _____

Preferred ePharmPro service hours for hospital: _____

Indicate Time Zone: _____

EST, CST (-1), MST (-2), PST (-3)

Estimated prescription volume in line items per night (example: 3 order sheets containing 2 medication orders on each is 6 line items): _____

Pharmacy operating system: _____

Employ Hospitalists? (Yes/No) _____ Hours of coverage: _____

Physician Order Management System:

(Choose One)

Fax: _____ OmniLink: _____ Pyxis Connects: _____ Other: _____

Automated Dispensing Cabinet:

Type: _____ Connected to patient profile? (Yes/No) _____

Are you running an electronic MAR? (Yes/No) _____ Type of MAR? _____



Necessary Hospital contacts:

Name	Position	Phone Number	E-mail Address
	Pharmacy Director		
	IT contact		
	Nursing Supervisor		
	Nursing Supervisor		
	Nursing Supervisor		
	Nursing Supervisor		
	Safety/Quality Officer		

I.T. Requirements (General Information):

Does the Pharmacy Staff have the capability to connect to the Pharmacy server from an off-site location? (Yes/No – advise) _____

What type of VPN or remote connectivity does your IT dept support?

Questions/ Comments:

How do you feel your hospital would benefit from these services at the present time?

Who are the Decision Maker(s) for implementation of ePharmPro services to your facility? If possible, please provide name(s), title(s) and contact information below:

