POLYCYSTIC KIDNEY DISEASE REGISTRY
PATIENT INFORMATION FORM

BCRenal
an agency of the Provincial Health Services Authority

Date completed (if completing this retrospectively from a chart, use the date of that visit): (DD/MM/YYYY) _____/_____/_____			
Identifying Information	Name:	PHN:	Date of Birth:
Primary Nephrologist:			
What is your patient's most recent BP? _____/_____ mmHg			
What medications is this patient taking? (check all categories that apply and provide drug names if known)			
Category	Name	Dose	Frequency
○ ACE inhibitor			
○ ARB			
○ Beta blocker			
○ Calcium channel blocker			
○ Diuretic	_____ _____	_____ _____	_____ _____
○ Other antihypertensives (please list):	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Is this patient taking other medications specifically for their PKD? ○ Yes (please list): _____ _____ _____ _____		○ No	○ I don't know

Please fax completed form, or if you prefer, fax a dictation containing all of the above information to **(604) 708-2109**.