CIMPKD
Centre for Innovative Management of Polycystic Kidney Disease

UHN Toronto General Hospital

# POLYCYSTIC KIDNEY DISEASE (PKD) RISK ASSESSMENT REFERRAL FORM

**CIMPKD TEL:** 416-340-4257 **CIMPKD FAX:** 416-340-4999

**PATIENT INFORMATION:** (Please fill out completely or attach patient demographic label)

Patient Name: _____

Date of birth (DD/MM/YYYY): _____

Gender: ☐ Male ☐ Female

OHIP number: _____

Address: _____

_____

Patient ID Sticker/Addressograph

Tel (H): _____ (C): _____ Height: _____ cm Weight: _____ kg

**ENCLOSED MEDICAL INFORMATION:**

- ☐ Diagnostic imaging report (MRI/US/CT Scan)
- ☐ Most recent lab report
- ☐ Previous genetic testing reports (if available)
- ☐ MRI CD (please mail to Dr. York Pei, 585 University Avenue, 8N-838, Toronto, ON M5G 2N2)

**REASON FOR ASSESSMENT:** *(Please check one or more options)*

- ☐ For possible Tolvaptan treatment
- ☐ For possible treatment of "mass effect" symptoms by liver and/or kidney foam sclerotherapy

**FOLLOW-UP OPTIONS:** *(Please check one or more management options should your patient be in **a high-risk category for progression and/or has at least one large (>5 cm) non-exophytic kidney cyst**)*

- ☐ Refer patient back to me; I will apply for drug coverage and initiate Tolvaptan treatment
- ☐ Apply for drug coverage, initiate Tolvaptan treatment and refer patient back to me once s/he is on a stable and maximally tolerable dose
- ☐ Apply for drug coverage, initiate Tolvaptan treatment, and co-manage patient once s/he is on a stable and maximally tolerable dose (via an online portal)
- ☐ Discuss with patient the potential use of foam sclerotherapy as an experimental treatment to reduce kidney volume and refer for the procedure if the patient agrees

**ADDITIONAL COMMENTS:**

_____

_____

_____

Physician Name: _____ Signature: _____ Date: _____

Billing Number: _____ Tel: _____ Fax: _____

Please fax to 416-340-4999 (Attn: CIMPKD)