

# Kidney Care Clinic: Learning Needs Questionnaire for New Patients with ADPKD

Rev: November 2019

Date completed: \_\_\_\_\_

## PATIENT INFORMATION LABEL

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

PHN: \_\_\_\_\_

To help us know what you would like to learn more about, please tell us what you know now by putting a check mark (✓) in the box that best describes you.

	I do not know much about this	I know something about this but would like to know more	I understand this very well	This does not apply to me
Polycystic Kidney Disease (PKD) and how it affects me				
Blood tests and what they mean for me				
Blood pressure and kidney care				
Diabetes and kidney care				
Resources to self-manage my care				
Diet measures to protect my kidneys				
Stress and coping with kidney disease				
Lifestyle changes necessary for kidney health				
How will PKD affect my work				
How will PKD affect my family				
Concerns about having children related to PKD and kidney disease				

### Right now, I am most concerned with:

\_\_\_\_\_

\_\_\_\_\_

### Other concerns I have that are not on the list are:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Please answer the questions below to help us know the best way to provide you with information about kidney disease.

1. What is your primary (main) language?

\_\_\_\_\_

2. How would you rate your English?

Good       Fair       Poor       None

3. Would it help to have an interpreter available to you?

Yes       No

4. How do you like to learn about your health?

- Books
- Pamphlets
- Newsletter
- Group sessions
- Videos
- Posters
- Internet
- Other: \_\_\_\_\_

5. Please let us know of anything else you would like to share to help us know you better:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for filling out this form.**