Urology Services
Thunder Bay

Prostate Diagnostic Assessment Program Referral Form

Place Patient Label with Barcode Here

Guidelines:

1. Primary Care Provider to complete referral.
2. Fax to Prostate Diagnostic Assessment Program (DAP) at **(807) 346-1445.**
3. Completed referral forms will be filed on the patient's health record **QUESTIONS? –** Contact Diagnostic Assessment Program at 807-684-6921

INDICATION FOR UROLOGY CONSULT Check all that apply

☐ High PSA* in Absence of Urinary Infection / Instrumentation * Age based normal upper limit PSA: ☐ 40-49 years: 2.5 ng/mL ☐ 50-59 years: 3.5 ng/mL ☐ 60-69 Years: 4.5 ng/mL

☐ Abnormal Digital Rectal Exam ☐ Abnormal Ultrasound of the Prostate (attach report)

☐ **First Degree** Family History of Prostate Cancer Specify Family Member(s) and Age of Diagnosis: 1._____ Age: _____ 2. _____ Age: _____ 3._____ Age: _____

Patient will be triaged and scheduled with Urology* as per Cancer Care Ontario guidelines.

* Urology Team: Dr. H. Elmansy, Dr. O. Prowse, Dr. W. Shahrour

PATIENT INFORMATION

Last Name, First Name: _____ Date of Birth (day/month/year) _____

Sex: ☐ Male ☐ Female ☐ Other Health Card Number: _____ Version Code: _____

Address _____ Telephone _____ Home: _____

_____ Work: _____ Cell: _____

Primary Contact (Last Name, First Name): _____

Relationship to Patient: _____ Phone Number: _____

☐ Patient incapable of giving his/her own Informed Consent

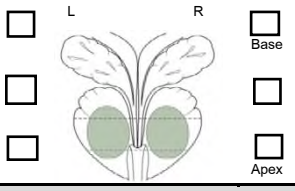
Patient to be accompanied by an interpreter at the time of appointment if they do not read/speak English.

REPORTS AND FINDINGS

Most recent PSA Values	Date of Test	Free/Total ratio (if available)
1.		
2.		
3.		

Digital Rectal Exam Findings

☐ Nodule
☐ Asymmetry
☐ Enlarged
☐ Normal



PATIENT MEDICAL HISTORY

Is patient on anticoagulants, ASA, NSAIDS or natural blood thinners?
☐ No ☐ Yes
If yes, list: _____
_____

Allergies:
☐ No known drug allergies
☐ Latex
☐ Penicillin
☐ Other: _____

☐ Acute medical condition requiring hospitalization in past year: _____

List any contact precautions (ie MRSA, VRE):_____

☐ Unexplained Bony Pain
☐ Unexplained Lower Back Pain
☐ Unexplained Weight Loss
☐ Lower Urinary Tract Infection
☐ History Prostate Cancer

☐ Cardiac Disorders
☐ Pacemaker/Internal Defibrillator
☐ Respiratory Disorders
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease

☐ Renal Insufficiency
☐ Gynecological Surgery
☐ Abdominal Surgery
☐ Coagulation Disorders
☐ Hemophilia
☐ Diabetes
☐ Communicable Diseases
☐ HIV
☐ Hepatitis C
☐ Tuberculosis
☐ Other: _____

List current medications/ supplements and other relevant history: (or attach list ☐)

PRIMARY CARE PROVIDER INFORMATION

Name:
Phone: Fax:
Signature: