Thunder Bay Regional Health Sciences Centre

PROSTATE DIAGNOSTICS ASSESSMENT PROGRAM REFERRAL FORM

GUIDELINES FOR USE:

1. Primary Care Provider to complete referral.
2. Fax to Prostate Diagnostic Assessment Program (DAP) at **(855) 975 2418 (toll free)**
3. Completed referral forms will be filed on the patient's health record
   QUESTIONS – Contact Diagnostic Assessment Program at 807-285-9292

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
Dr. A. Kotb
Dr. A. Zakaria

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

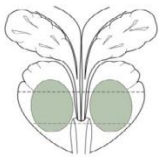
Patient to be accompanied by an interpreter at the time of appointment if they do not read/speak English.

REPORTS AND FINDINGS – Please attach available lab reports with your referral

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

Digital Rectal Exam Findings L R

☐ 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: Date: