

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: _____

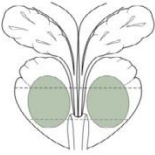
Primary Contact Last Name: _____ First Name: _____

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)	Digital Rectal Exam Findings	L	R
1.			☐ Nodule ☐ Asymmetry ☐ Enlarged ☐ Normal		Base Apex
2.					
3.					

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: