Quality Health Care
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Health

PROSTATE ASSESSMENT CLINIC

URGENT REFERRAL FOR POSSIBLE PROSTATE CANCER

Tel: 519 376-2121, Ext. 2608 Fax: 519 372-3931

Surname		Given Name	Date of Referral (dd/mm/yyyy)	
Street		City	Province	Postal Code
Home Phone ( )	Work ( )	DOB (dd/mm/yyyy)	Gender M ☐ F ☐	
OHIP Number		VC	☐ Translator Needed/Language	
Primary Contact Name		Primary Phone Number ( )	Relationship	
Referring Physician Name (print)	Physician Number	Phone ( )	Fax ( )	

Please FAX consultant notes including HISTORY OF PATIENT, CURRENT MEDICATIONS AND REPORTS OF ANY PREVIOUS IMAGING OR BIOPSY.

Family History of Prostate Cancer ☐ yes ☐ no

PLEASE INCLUDE A RECORD OF ALL PREVIOUS PSA RESULTS

Reason for Referral:

☐ High PSA in the Absence of Urinary Infection/Instrumentation

☐ Abnormal Digital Rectal Examination

Date of Patient's Initial Consult with Referring Physician: _____
(dd/mm/yyyy)

Signature of Referring Physician (Mandatory) _____ Date: ____/____/____