St JOSEPH's HEALTH CARE LONDON *in collaboration with the South West Regional Cancer Program*

PROSTATE DAP REFERRAL FORM

Date: (YYYY/MM/DD) _____

Diagnostic Assessment Program
Nurse Navigator
Telephone: 519.646.6000 ext. 65622 | Fax: 519-646-6217

REFERRAL CRITERIA TO PROSTATE DIAGNOSTIC ASSESSMENT PROGRAM:

Check (✓) all that apply: ☐ Abnormal DRE suspicious for cancer
☐ PSA >10
PSA ≥ age based PSA value confirmed

Aged 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

PATIENT INFORMATION:

Patient Name:			
Address:			
		DOB: (YYYY/MM/DD)	
HIN:	VC:	Translator Required: ☐ Yes ☐ No	Language:
Telephone:		Telephone (Alternate):	

BEFORE COMPLETING THE REFERRAL ENSURE:
2 PSA results, and 1 Free/Total ratio in the last 6 months and at least 1 month apart are available

MOST RECENT PSA VALUES	DATE OF TEST (YYYY/MM/DD)	FREE/TOTAL RATIO (required for 1 PSA)
1.		
2.		
3.		

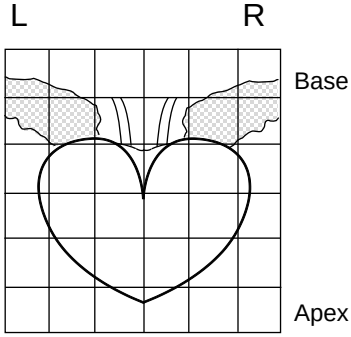
PERTINENT MEDICAL AND SURGICAL HISTORY:

Pertinent Family History of Prostate Cancer: Age at Dx:

ALLERGIES: ☐ NKA ☐ Yes, specify:

DIGITAL RECTAL EXAM FINDINGS:

PLEASE MARK DRAWING WITH FINDINGS



☐ Nodule ☐ Asymmetry ☐ Enlarged ☐ Normal

CURRENT MEDICATIONS: ☐ Or send e-list of current medications.

DRUG	DOSE	FREQUENCY	DRUG	DOSE	FREQUENCY

Has the patient had any previous TRUS or pelvic CT/MRI? ☐ Yes ☐ No

If *YES*, Where? When?

Referring Physician: *(please print)*	Telephone:
Signature:	Fax: