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Prostate Cancer Patient Referral Form
Prostate Diagnostic Assessment Program

Diagnostic Assessment Program
St. Catharines Site
1200 Fourth Avenue, St. Catharines, ON L2S 0A9
Phone: 905–378–4647 Ext 49144 Fax: 289–398–1033

Patient Name:		Date of Birth: (dd/mm/yyyy)
Height: Weight: Allergies:		Blood Thinners: ☐ No ☐ Yes If YES, name
Patient's Pharmacy:		
Health Card Number:		Version Code:
Address:		
City:	Province:	Postal Code:
Home Phone:	Cell Phone:	
Alternate Contact:	Number:	Relationship:
Referring Physician:	Phone Number:	Fax Number:
Family Physician:	Phone Number:	Fax Number:

Prostate Specific Antigen (PSA)
Please include Free / Total Ratio

PSA (ng/mL)	Date (dd/mm/yyyy)	Free / Total

Min 2 values 1 from within the last 2 months

PSA should be repeated 8 weeks after UTI or catheterization to prevent a false positive result

Age greater than 70 - screening not recommended unless GU symptoms or anticipated extended longevity

Family History of Prostate Cancer

- ☐ Father
- ☐ Brother(s)
- ☐ Grandfather(s)
- ☐ Son(s)
- ☐ Previous Prostate Cancer Diagnosis

Digital Rectal Exam (DRE)

- ☐ Normal Examination
- ☐ Prostate Nodule
- ☐ Prior Prostate Biopsy Date: ________________ (dd/mm/yyyy)

Rev. 05/2024(v2)

★ **CLINICAL INFORMATION (Please include: Patient Profile, copies of labs, relevant reports within the past year). If not included, referral will be sent back.** ★

Please ensure referral is complete. Incomplete referrals will be returned.

REF57

Chart Copy – Do Not Destroy