Prostate Diagnostic Assessment Clinic
Surgical Clinic Area
2867 Ellesmere Road, Toronto M1E 5E9
Phone: 416-284-8131 Ext. 7111
Fax: 416-281-5092

Patient Name: (print, first, last)

OHIP #: _____ DOB: ____/____/_____
dd /mm/yyyyy

Complete or place patient label

Prostate Assessment Clinic – Physician Referral

Please fax to 416-281-5092

Patient Address:	
Patient Phone Number:	Patient Alternate Phone Number:
Family Physician if different from referring physician:	

REASON FOR REFERRAL:

☐ Elevated PSA ☐ Family History of Prostate Cancer

☐ Abnormal Prostate Exam ☐ Concerned Regarding Prostate Cancer

Details:_____

_____

RESULTS PERTINENT TO REFERRAL:

PSA Level (most recent): _____ Date_____

****Please include / attach all previous PSA values****

Imaging: _____

Other: _____

SIGNIFICANT MEDICAL HISTORY:

_____

_____

_____

_____

_____

MEDICATIONS:_____

_____

_____

_____

Referring Physician Name:	Billing #:
Referring Physician Signature:	Date: ____/____/____
Phone Number:	Fax Number:
CLINIC USE ONLY	
Date referral received: ____/____/____	Appointment : ____/____/____ Time: _____

Form ID: 2472

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