Prostate Diagnostic Assessment Unit
Oncology Services, Suite 105, The Court,
2867 Ellesmere Road, Toronto M1E 5E9
Phone: 416-284-8131 Ext. 5318
Fax: 416-281-7228

Patient Name: (print, first, last)

____

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

Complete or place patient label

Prostate Assessment Clinic – Physician Referral

Please fax to 416-281-7228

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:

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____

____

MEDICATIONS:____

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

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