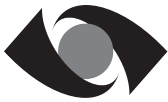

SOUTHLAKE
REGIONAL HEALTH CENTRE

Medical Arts Building
581 Davis Drive, 3rd Floor
Newmarket, ON L3Y 2P6
Tel: 905-895-4521, ext. 2960
Fax (905) 952-2819

Diagnostic Assessment Unit

Health Record #: ______________________ Complete or place patient label here
Patient Name: *(Print first, last)* ______________________
DOB: dd / mm / yy   Age: ______   ❑ Female ❑ Male
OHIP #: ______________   Version Code: ______________
Account #: ______________   Date of Admission: dd / mm / yy

Prostate Assessment Clinic - Physician Referral

Please fax to 905-952-2819

Patient Address:

Patient Phone Number: | **Patient Alternate Phone Number:**

Primary Care Physician Name: *(if different from referring Physician) (print first, last)*

REASON FOR REFERRAL:

❑ Elevated PSA
❑ Family History of Prostate Cancer
❑ Abnormal Prostate Exam
❑ Concerned Regarding Prostate Disease

Details: ____
____
____

RESULTS PERTINENT TO REFERRAL

PSA Level: ________   Date drawn: dd / mm / yy

Imaging: ____

Other: ____

SIGNIFICANT MEDICAL HISTORY:
____
____
____

MEDICATIONS: ____
____
____

Fall Risk Assessment: Any falls in the past 3 months? ❑ Yes ❑ No   Do you feel unsteady when walking? ❑ Yes ❑ No

Taking medication(s) which cause dizziness? ❑ Yes ❑ No

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name: *(print first, last)* | **Billing #:**

Referring Physician Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**

CLINIC USE ONLY

Date referral received: dd / mm / yy | **APPOINTMENT – Date:** dd / mm / yy   **Time:** ____________

S-PROACPR