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: mm / dd / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: mm / dd / 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
❑ Abnormal Prostate Exam
❑ Family History of Prostate Cancer
❑ Concerned Regarding Prostate Disease

Details: _____

_____

_____

RESULTS PERTINENT TO REFERRAL

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

Imaging: _____

Other: _____

SIGNIFICANT MEDICAL HISTORY:

_____

_____

_____

MEDICATIONS: _____

_____

_____

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:** mm / dd / yy

Phone Number: | **Fax Number:**

CLINIC USE ONLY

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