Prostate Cancer Patient Consultation Form

Name: _____________________________________
Address: ___________________________________

DETECTION:
Symptoms:________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Initial PSA:_______ Normal Range: ________ Most Recent PSA: ___________
Free vs. Bound PSA: __________

EVALUATION:
Yes: ______ No: ______ Positive DRE?
Yes: ______ No: ______ Endo-rectal MRI?
Yes: ______ No: ______ CT pelvis/abdomen?
Yes: ______ No: ______ Bone scan?
Yes: ______ No: ______ Chest X-ray?

Prostascint Imaging? Positive:_______ Negative:___________

RT-PCR Blood Assay? Positive: ______ Negative: _________

PAP (prostatic acid phosphatase) results: ________ Normal range:_________

Serum chemistries results:
BUN Creatine: __________/_________

Alkaline phosphatase: __________________________(nl to _______)
LDH ____________ (nl to __________)
Hematocrit ______________
Platelet count ______________

Needle biopsy performed? Yes: ______ No: _______
Number of cores: ________
Pathology comments:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

**DIAGNOSIS:**
Yes: ______  No: _______ Prostate Cancer?
Yes: ______  No: _______ Right Lobe involved?
Yes: ______  No: _______ More than 1/2 of lobe?
Yes: ______  No: _______ Left Lobe involved?
Yes: ______  No: _______ More than 1/2 of lobe?

Tumor size:____________

Yes: ______  No: _______ Seminal Vesicle involved?

DNA Ploidy Analysis: Diploid _____  Aneuploid _____  Tetraploid ______

Gleason Grade: ______ + _______ = ________

Stage: _____________

Partin Table Score: __________

**TREATMENT:**
Detail any previous treatments for prostate cancer or any other urological condition:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

What are the options available to me:

_____  Radical Prostatectomy
_____  Laparoscopic Radical Prostatectomy
_____  Cryo-Surgery
_____  Conformal Beam Radiation
_____  Radiation Seed Implants (brachytherapy)
_____  Hormonal Therapy
_____  Combination Hormonal Blockade
_____  Intermittent Hormonal Therapy
_____  Chemotherapy
_____  Combination Chemotherapeutic Protocol
_____  Clinical Trial
Watchful Waiting (monitored by physician)

Other

Do you recommend hormonal therapy prior to, or after, the treatment selected? Yes: _____ No: _____

Why?

What are the side-effects to the recommended treatment:?
incontinence:

sexual dysfunction:

other:

How many of these procedures have you done? ____ How frequently now? ____

What is the prognosis for:
survival
recurrence

2nd opinion options:

Urological oncologist

- Radiation oncologist

- Medical (genito-urinary) oncologist

- Alternative/Complementary Medicine specialist

Notes: ____________________________________________________________

________________________________________________________________

________________________________________________________________

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