WEST OF SCOTLAND REGIONAL PROSTATECTOMY SERVICE REFERRAL FORM

Patient Name **Date of Birth** **CHI**	
Patient Address and Tel Contact	
GP Name and Address	
Age	
Clinical TNM Stage	T N M
Biopsy Gleason Score	
Initial PSA	
Clinical Presentation	◯ Asymptomatic ◯ LUTS ◯ Progression on Active Surveillance ◯ Other - specify
DRE	◯ Benign feeling small ◯ Benign feeling enlarged ◯ Nodule (specify side) ◯ Clinically T3
Prostate Volume	
Date of Primary Referral	
Date of Biopsy	***Pathology Report attached** ◯
Type of Biopsy	◯Standard TRUS Biopsy ◯Template Biopsy ◯Targeted Biopsy
Proportion of cores	Right Total ___ Left Total ___ Targeted Total ___ Right Positive ___ Left Positive ___ Targeted Positive ___ Right Negative ___ Left Negative ___ Targeted Negative ___
MRI Date	***MRI Report attached** ◯
MDT Date	
MDT Recommendation	

Patient options	◯Has had discussion of other treatments ◯Awaiting to discuss other options
PMH + Medications: <u>Also specify if positive h/o:</u> ◯***Glaucoma** ◯***COPD** ◯***Cardiovascular illness** ◯***Prior abdo surgery** ◯***Prior hernia surgery** ◯***Prior radiotherapy**	
BMI	
Any other information	
Referred by: **Date:**	

<u>Please attach reports for MRI scans, Bone scans, Pathology and PSA results</u>

Email this form fully filled together with above attached reports to:

WosRobotics@ggc.scot.nhs.uk

Julie.Clyde@ggc.scot.nhs.uk

<u>Official use:</u> <u>Baseline data</u>

IPSS score (if LUTS) _____

IIEF score _____

ICIQ-SF score _____