UNIVERSITY OF Cincinnati

College of Medicine
Department of Radiology
University of Cincinnati Medical Center
PO Box 670761
Cincinnati, OH 45267-0761

Phone: (513) 584-1764
Fax: (513) 584-0431

PATIENT REFERRAL AND CLINICAL DATA

Please fill out the following information for the following patient who you are referring for a prostate MRI/MRSI staging examination. Please fax to us at (513) 584-0431 prior to the appointment and send original lab and pathology reports when available.

1) Patient name: _____ Date of Birth: _____
Patient Phone Number: _____

Circle the racial category below to which you most closely associate:

Black/African-American Asian White/Caucasian Hispanic/Latino

Native Hawaiian or other Pacific Islander Mixed/Other (specify) _____

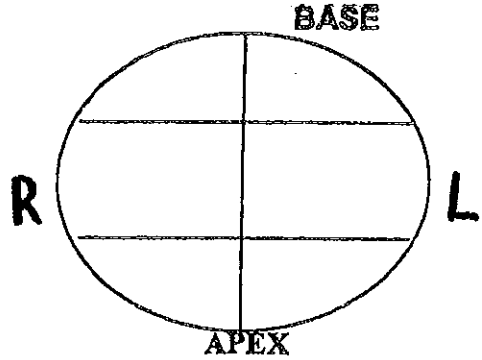
2) Current PSA Level: _____ Date: _____
Bone Scan Date: _____ Metastases:

PSA History

Level	Date

3) Date of first positive Biopsy:_____
On the diagram, mark positive area with:
a. Gleason Score and Sum, and
b. % or mm of core positive

Total # of negative cores: _____
Total # of positive cores: _____



What kind of therapy has been delivered?
☐ No therapy/watchful waiting/diet or herbal therapy
☐ Surgery Date:_____ Type: _____
☐ Radiation Date:(start and stop): _____Type_____☐ with hormones
Date (start and stop): _____Type_____☐ with hormones

List any sedatives prescribed to this patient_____
Physician's name (Print) _____Phone:_____Fax:_____