

**CLS Prostate Specific Antigen (PSA) History Form**  
**DO NOT USE THIS REQUEST FOR ORDERING OTHER PROCEDURES**

*Please note that the Alberta Clinical Practice Guideline for "Use of PSA and Screening for Prostatic Cancer" does not promote the use of this test for routine screening in low risk, asymptomatic men.*



DATE		REFERRING LOCATION			
PATIENT I.D. NO.		SEX M	DATE OF BIRTH M   D   Y		
LAST	FIRST	MIDDLE		AGE	
PHYSICIAN			ADMISSION DATE		
ALBERTA PERSONAL HEALTH CARE NUMBER (REQUIRED FOR PROCESSING)					
OUT OF PROVINCE HEALTH NUMBER (IF APPLICABLE)					

D.R.E. + VE (Digital Rectal Examination) <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a brother or father who was diagnosed with prostate cancer before 70 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Known prostate cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient had an elevated PSA previously Date: _____      PSA Conc: _____		
Post prostatectomy <input type="checkbox"/> Yes <input type="checkbox"/> No	Advanced disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Post radiotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature	Ordered by		

- THE SAMPLE WILL NOT BE PROCESSED WITHOUT THE ABOVE INFORMATION -

CLS Form #CH3013 01-08-24

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