Longitudinal Followup for Prostate Cancer

1) Since your last contact with us, has your cancer recurred? ☐ Yes ☐ No

2) If yes, please specify when _____

What were you last PSA values?

3) PSA value _____

4) on date _____

5) PSA value _____

6) on date _____

7) PSA value _____

8) on date _____

9) Since our last contact, have you had any other treatment for your prostate cancer, such as radiation therapy, chemotherapy, hormone therapy, or surgery? ☐ Yes ☐ No

If yes, please specify the type(s) of treatment and date(s) involved

10) Treatment 1: _____

11) Start date (or date of surgery) _____

12) Stop date (for radiation, chemotherapy or hormone therapy) _____

13) Treatment 2 _____

14) Start date (or date of surgery) _____

15) Stop date (for radiation, chemotherapy, or hormone therapy) _____

16) May we contact, or continue to contact, your physician(s) to obtain copies of your medical records? ☐ Yes ☐ No

If yes, please print, sign and return the attached HIPAA Patient Authorization form

5. Please send us the contact information for your current following physician

17) First Name: _____

Last Name

Address

City

State

Postal (ZIP) Code

18) 6. May we contact you by telephone if we have further questions about your responses? ☐ Yes ☐ No

19) Your phone number _____

20) Phone number type

- ☐ Work
- ☐ Home
- ☐ Mobile

21) Best time to call _____

22) 7. If you would prefer to receive these follow-up notices at a different E-MAIL address, please write the new E-MAIL address here _____