Prostate Cancer Supportive Care (PCSC) Program
Level 6 Station 3, 2775 Laurel Street
Vancouver, BC V5Z 1M9
Phone: 604-875-4485 or Fax: 604-875-4637

PCSC Sexual Health Service

☐ Group Education Session ☐ Individual Consult Date of Referral: ____________________________

***Please attach relevant history, consults and blood work that will assist with the referral (incomplete referrals will not be processed)**

Please complete patient information or attach a label

Patient Name: ____

Date of Birth (MM-DD-YYYY): __________________________PHN#: ______________________________

Address: ____

Telephone: (h)__________________(w/c)________________ Email ___________________________________

Partnered: ☐ Yes ☐ No (M/F/Unknown)

Referring Doctor: ____

Family Doctor: ____

Urologist: _________________________________ Rad. Oncologist: _________________________________

Details: ____

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Relevant medical and psychiatric history: ____

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Medications/Allergies: ____

____

Date(s) of PCa Treatment/Surgery: ____

PCa Treatment Type:
- ☐ Active Surveillance
- ☐ Brachytherapy
- ☐ External Beam Radiation
- ☐ Open/Laparoscopic Prostatectomy
- ☐ Robotic Prostatectomy
- ☐ Other ____________________

Nerve-Sparing? ☐ None ☐ Unilateral (Left/Right) ☐ Bilateral ☐ Unknown

Hormone Therapy? ☐ No ☐ Yes (current) ☐ Yes (past)

Previous Treatments for Sexual Concerns:

- ☐ None
- ☐ PDE5 Inhibitor: ________________
- ☐ Ejaculatory Treatment
- ☐ Vacuum Pump
- ☐ Injection Therapy
- ☐ Other: ____
- ☐ MUSE
- ☐ Sexual Therapy/Counselling

Completed by Clinic Staff Appointment Date & Time: ____________________________________