

CLINICAL REPORT FORM – PROSTATE BIOPSY NEGATIVE STUDY

NAME OF PHYSICIAN/INSTITUTION: _____

PATIENT NAME: _____

DATE OF PROSTATE BIOPSY: _____

DATE OF CONSENT FOR BIOPSY NEGATIVE STUDY: _____

INITIAL PSA AND DATE (THAT PROMPTED THE BIOPSY): _____

3 MONTH PSA AND DATE: _____

6 MONTH PSA AND DATE: _____

PRODUCT ISSUED TO THE PATIENT? (PLEASE CIRCLE THE PRODUCT)

PRODUCT A

PRODUCT B

PLEASE **MAIL** A COPY OF THIS COMPLETED FORM WITH A COPY OF THE
PSA REPORTS AND THE PROSTATE BIOPSY RESULTS TO:

**THE PROSTATITIS AND PROSTATE CANCER CENTER
RONALD E. WHEELER, M.D.
1819 MAIN STREET, SUITE 401
SARASOTA, FLORIDA 34236**

IF ANY QUESTIONS, PLEASE DON'T HESITATE TO CALL ME AT 970-259-4081
OR 941-957-0007. THANK YOU!