MEDICAL RECORDS NEEDED FOR EVALUATION OF PROSTATE CANCER AT RADIATION ONCOLOGY OF ATLANTA

I. **PSA reports** – copies of all of your PSA values from the beginning. You may find it helpful to write them down in order from newest to oldest on a separate sheet of paper; some patients also choose to graph their results. Either way, if you do this, you will have a PSA record for future reference. Please include your lab sheet with your labs.

2. **Biopsy (pathology) report** – the pathologist's written report of the prostate needle biopsy.

3. **Biopsy slides** --- the actual glass slides from which your diagnosis of prostate cancer was made. If you wish to be treated at ROA, an expert pathologist will review these biopsy slides to confirm the diagnosis of prostate cancer and the Gleason Score. You will receive a separate bill from Milstead Pathology for this second opinion. Please note that we will not have your slides reviewed unless you choose treatment here at ROA or specifically request we do so.

4. **Prostate CAT scan** – You may send the actual films or the images on a CD, but we must have the images to determine whether or not you are a candidate for treatment as well as the number of seeds for the implant. If you have not had a prostate CT, one will be done at the time of your consultation.

5. **Bone scan report** –If one was done. In the last 5 years, many men have not required bone scans.

6. **A "Letter of Medical Clearance"** from your doctor stating you are medically fit for the anesthesia required to perform a prostate seed implant. If you are over age 45 or if you have a history of heart problems, an EKG plus the report and a current chest x-ray report will also be needed.

7. **Please complete and return the following evaluation forms.** The forms are important to understanding your overall health and prostate symptoms.
    - Initial Health questionnaire
    - Sexual Health Inventory Form
    - American Urological Association (AUA) questionnaire
    - EPIC questionnaire

8. **Consultation and office notes** from your family doctor and urologist.

9. **Insurance cards (primary and secondary)** – make a copy of the front and back. Note that sometimes your insurance will tell you which hospital to use for your implant and which urologist we can consult.

10. **Visa or passport copy** if you live outside the United States.

Should you have any questions, please feel free to call our Prostate Seed Coordinator at 404-851-8622, or our scheduler, at 404-303-3896. You may also send an email to contact@radoncatlanta.com

Request for Medical Clearance Letter:
Outpatient Prostate Seed Implant

For patient: _____ Date of Birth: _____

Dear Doctor:

This patient has been diagnosed with prostate cancer, and has requested treatment with Radiation Oncology of Atlanta. Our treatment approach involves seed implant followed by a six to seven week course of external beam irradiation. The success rate of this program is excellent with 10 year results at least equal to those of the major radical prostatectomy series reported. Peer-reviewed articles describing the results of this approach are available at your request.

The implant process is as follows. The patient is admitted under the care of a urologist. The seed implant is a minor surgical procedure typically performed under general anesthesia, but spinal if necessary. After induction of anesthesia by either technique, the patient is placed in the dorsal lithotomy position and a trans-rectal ultrasound probe is inserted. A needle guide is placed against the perineum and, under ultrasound control, needles are passed through the perineum and into the prostate. After confirming the needle arrangement, seeds are deposited as the needles are withdrawn. No incisions are made. Typically minimal bleeding is encountered with the exception of an occasional perineal hematoma. After completion of the procedure the urologist will perform a cystoscopy to be certain that there are no stray seeds or clots in the bladder requiring irrigation and removal. The patient is discharged either a few hours later or the following morning, based on the discretion of the admitting urologist.

We ask your assistance in ordering any tests you feel appropriate for this patient. For patients over 50, the anesthesia staff would request you include a chest x-ray and ECG. Assuming all is in order, please provide a letter of preoperative clearance for our anesthesia staff. Should you note special circumstances or requirements for this patient, please do not hesitate to include these recommendations. Please FAX **the letter of clearance, along with any reports, to 404-459-1694.**

Thank you for your assistance in this important matter. Should you have any questions, please do not hesitate to call our Prostate Seed Coordinator at 404-851-8622.

Sincerely,

W. Hamilton Williams, MD

EPIC-26

The Expanded Prostate Cancer Index Composite

Short Form

This questionnaire is designed to measure Quality of Life issues in patients with Prostate cancer. To help us get the most accurate measurement, it is important that you answer all questions honestly and completely.

Remember, as with all medical records, information contained within this survey will remain strictly confidential.

Today's Date (please enter date when survey completed): Month_____Day_____Year_____

Name (optional): _____

Date of Birth (optional): Month_____Day_____Year_____

Do Not Mark in This Space

1. Over the **past 4 weeks**, how often have you leaked urine?

   More than once a day..... 1
   About once a day..... 2
   More than once a week..... 3 (Circle one number) 23/
   About once a week.....4
   Rarely or never..... 5

2. Which of the following best describes your urinary control **during the last 4 weeks**?

   No urinary control whatsoever..... 1
   Frequent dribbling..... 2 (Circle one number) 26/
   Occasional dribbling..... 3
   Total control..... 4

3. How many pads or adult diapers <u>per day</u> did you usually use to control leakage **during the last 4 weeks**?

   None 0
   1 pad per day.....… 1
   2 pads per day..... 2 (Circle one number) 27/
   3 or more pads per day..... 3

4. How big a problem, if any, has each of the following been for you **during the last 4 weeks**?

   (Circle one number on each line)

	No <u>Problem</u>	Very Small <u>Problem</u>	Small <u>Problem</u>	Moderate <u>Problem</u>	Big <u>Problem</u>	
a. Dripping or leaking urine ….....	0	1	2	3	4	28/
b. Pain or burning on urination.....	0	1	2	3	4	29/
c. Bleeding with urination.....	0	1	2	3	4	30/
d. Weak urine stream or incomplete emptying.....	0	1	2	3	4	31/
e. Need to urinate frequently during the day.....	0	1	2	3	4	33/

5. Overall, how big a problem has your urinary function been for you **during the last 4 weeks**?

   No problem..... 1
   Very small problem..... 2
   Small problem.....3 (Circle one number) 34/
   Moderate problem..... 4
   Big problem..... 5

Do Not Mark in This Space

6. How big a problem, if any, has each of the following been for you? (Circle one number on each line)

	No Problem	Very Small Problem	Small Problem	Moderate Problem	Big Problem	
a. Urgency to have a bowel movement	0	1	2	3	4	49/
b. Increased frequency of bowel movements.....	0	1	2	3	4	50/
c. Losing control of your stools.....	0	1	2	3	4	52/
d. Bloody stools	0	1	2	3	4	53/
e. Abdominal/ Pelvic/Rectal pain...	0	1	2	3	4	54/

7. Overall, how big a problem have your bowel habits been for you **during the last 4 weeks**?

No problem..... 1
Very small problem..... 2
Small problem..... 3 (Circle one number) 55/
Moderate problem..... 4
Big problem..... 5

8. How would you rate each of the following **during the last 4 weeks**? (Circle one number on each line)

	Very Poor to None	Poor	Fair	Good	Very Good	
a. Your ability to have an erection?.....	1	2	3	4	5	57/
b. Your ability to reach orgasm (climax)?.....	1	2	3	4	5	58/

9. How would you describe the usual QUALITY of your erections **during the last 4 weeks**?

None at all..... 1
Not firm enough for any sexual activity..... 2
Firm enough for masturbation and foreplay only..... 3 (Circle one number) 59/
Firm enough for intercourse..... 4

10. How would you describe the FREQUENCY of your erections **during the last 4 weeks**?

I NEVER had an erection when I wanted one..... 1
I had an erection LESS THAN HALF the time I wanted one..... 2
I had an erection ABOUT HALF the time I wanted one ..... 3 (Circle one number) 60/
I had an erection MORE THAN HALF the time I wanted one..... 4
I had an erection WHENEVER I wanted one..... 5

Do Not Mark in This Space

11. Overall, how would you rate your ability to function sexually **during the last 4 weeks**?

Very poor	1		
Poor	2		
Fair	3	(Circle one number)	64/
Good	4		
Very good	5		

12. Overall, how big a problem has your sexual function or lack of sexual function been for you **during the last 4 weeks**?

No problem	1		
Very small problem	2		
Small problem	3	(Circle one number)	68/
Moderate problem	4		
Big problem	5		

13. How big a problem **during the last 4 weeks**, if any, has each of the following been for you? (Circle one number on each line)

	No Problem	Very Small Problem	Small Problem	Moderate Problem	Big Problem	
a. Hot flashes	0	1	2	3	4	74/
b. Breast tenderness/enlargement	0	1	2	3	4	75/
c. Feeling depressed	0	1	2	3	4	77/
d. Lack of energy	0	1	2	3	4	78/
e. Change in body weight	0	1	2	3	4	79/

THANK YOU VERY MUCH!!

Radiation Oncology of Atlanta

American Urologic Association--International Prostate Symptom Score

Name:_____Date:_____

Please choose the ***single best answer*** for each question below.

	None	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Over the past month, how often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**
Over the past month, how often do you have the sensation of not completely emptying your bladder after urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Over the past month, how many times have had to urinate less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Over the past month, how often have you found that you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
Over the past month, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
Over the past month, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
Over the last month, how many times, on average do you urinate during the night, before getting up in the AM?	**None**	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**>5 Times**
Total symptom score= Sum of questions 1-7						

Do you take any medications such as Cardura, Hytrin, Uroxatral or Flomax? _____

SEXUAL HEALTH INVENTORY FOR MEN

PATIENT NAME:_____ **DATE OF EVALUATION**_____

PRE IMP XRT FU (Months after implant)_____

Write the number of the response that **best describes** your abilities **WITHOUT VIAGRA or similar drugs** in the column labeled "**A**". Please select **only one** response for each question. If you **are taking a "HELPER" drug like Viagra or something else**, please answer **TWICE, once** according to how your erections are **WITHOUT** the Helper aid in **Column A AND AGAIN** with the aid of the Helper, in **Column B**.

Do you take Viagra, Cialis or Levitra or other Helpers? ☐ **No** ☐ **Yes**

NATURAL **HELPER**

Over the past 4 weeks:

1. **How do you rate your <u>confidence</u> that you could get and keep an erection?** **A.**_____ **B.**_____
   1. Very low
   2. Low
   3. Moderate
   4. High
   5. Very High

2. **When you had erections with sexual stimulation, <u>how often</u> were your erections hard enough for penetration?** **A.**_____ **B.**_____
   0. No sexual activity
   1. Almost never or never
   2. A few times(much less than half the time)
   3. Sometimes (about half the time)
   4. Most times (much more than half the time)
   5. Almost always or always

3. **During sexual intercourse, <u>how often</u> were you able to maintain your erection after you had penetrated (entered) your partner?** **A.**_____ **B.**_____
   0. Did not attempt intercourse
   1. Almost never or never
   2. A few times (much less than half the time)
   3. Sometimes (about half the time
   4. Most times (much more than half the time)
   5. Almost always or always

4. **During sexual intercourse, <u>how difficult</u> was it to maintain your erection to completion of intercourse?** **A.**_____ **B.**_____
   0. Did not attempt intercourse
   1. Extremely difficult
   2. Very difficult
   3. Difficult
   4. Slightly Difficult
   5. Not difficult

5. **When you attempted sexual intercourse, <u>how often</u> was it satisfactory for you?** **A.**_____ **B.**_____
   0. Did not attempt intercourse
   1. Almost never or never
   2. A few times (much less than half the time)
   3. Sometimes (about half the time)
   4. Most times (much more than half the time)
   5. Almost always or always

SCORE: _____ _____

6. **How often do you have sexual intercourse with a partner?** **A.**_____ **B.**_____
   1. I am capable of satisfactory sexual intercourse, but I have not attempted in the last six months or since last filling out this form
   2. Not at all, I cannot get an erection
   3. Less than once a month
   4. 1 to 3 times a month
   5. 1 time a week
   6. 2 to 3 times a week
   7. More than 4 times a week