Name:_____ Date _____

Laparoscopic Prostatectomy for Chronic Prostatitis: A Phase II non-Randomized Clinical Trial

APPLICATION

Please complete pages 2-5 and fax them to us at (305)936-0498. You may instead scan and email the pages to prostatitis@laprp.com

Please also fax us any relevant medical records such as PSA results, biopsy reports, scan findings, doctor notes, and the like.

Please feel free to also attach a narrative in your own words about your situation. This will help us to better understand your situation.

If you have any questions please call us directly at (305)936-0474. Ask to speak with Hope or Ruth.

Thank you.

Name:_____ Date _____

Laparoscopic Prostatectomy for Chronic Prostatitis: A Phase II non-Randomized Clinical Trial

City: _____ **State**: _____ **Referred by:** _____

1) **What is your age**: _____ **height**: _____ **weight**: _____

2) Do you have: **diabetes** _____ **high blood pressure** _____

high cholesterol _____ **heart disease** _____ **trouble breathing** _____

3) Do you smoke? ____ When did you quit?_____ Packs per day? ____ For how many years? _____

4) Please list operations you've had:

_____

5) Please list your medications, including aspirin and pain medication, and doses:

_____

6) Allergies: _____

7) Picture: If it's not difficult please email us a photo of yourself; the email is prostatitis@laprp.com

THE KRONGRAD INSTITUTE

Name:_____ Date _____

NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

		Yes	No
a.	Area between rectum and testicles (perineum)	☐1	☐0
b.	Testicles	☐1	☐0
c.	Tip of the penis (not related to urination)	☐1	☐0
d.	Below your waist, in your pubic or bladder area	☐1	☐0

2. In the last week, have you experienced:

a.	Pain or burning during urination?	☐1	☐0
b.	Pain or discomfort during or after sexual climax (ejaculation)?	☐1	☐0

3. How often have you had pain or discomfort in any of these areas over the last week?

☐0 Never
☐1 Rarely
☐2 Sometimes
☐3 Often
☐4 usually
☐5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it over the last week?

☐ 0 NO PAIN ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating during the last week?

☐0 Not at all
☐1 Less than 1 time in 5
☐2 Less than half time
☐3 About half time
☐4 More than half time
☐5 Almost always

6. How often have you had to urinate again less than 2 hours after you finished urinating, over the last week?

☐0 Not at all
☐1 Less than 1 time in 5
☐2 Less than half time
☐3 About half time
☐4 More than half time
☐5 Almost always

Impact of symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

☐0 None
☐1 Only a little
☐2 Some
☐3 A Lot

8. How much did you think about your symptoms during the last week?

☐0 None
☐1 Only a little
☐2 Some
☐3 A Lot

Quality of life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

☐0 Delighted
☐1 Pleased
☐2 Mostly Satisfied
☐3 Mixed (about equally satisfied and dissatisfied)
☐4 Mostly dissatisfied
☐5 Unhappy
☐6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index

Pain: Total of items 1 a, 1 b, 1 c, 1 d, 2a, 2b, 3, and 4 =_____

Urinary symptoms: Total of items 5 and 6 =_____

Quality of life impact: Total of items 7, 8, and 9 =_____

Total score (range 0-43): =_____

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Name:_____ Date _____

REGISTRATION

Date of Birth: _____ Social Security Number: _____-- _____--_____

Home address: _____

City: _____ State: _____ Zip Code: _____

Home phone: (_____)_____ Home fax: (_____)_____

Cell phone: (_____)_____ Pager: (_____)_____

Email: _____ Marital Status: _____

Next of Kin: _____ Relation: _____ Next of Kin Phone: (____)_____

Occupation: _____ Retired: yes / no

Employer: _____ Location: _____

Work phone: (_____)_____ Work fax: (_____)_____

PRIMARY Insurance: _____ Policy Number: _____

Insured Name: _____ Relation to Patient: _____

Group Number: _____

SECONDARY Insurance: _____ Policy Number: _____

Insured Name: _____ Relation to Patient: _____

Group Number: _____

To complete the medical record, request pre-operative consultation, and report the results of your medical care, we must have the names and contact numbers of your primary physician, urologist, and other involved physicians. When your care progresses, we will be forwarding copies of your medical records to the doctors you list here. In addition, we may share results with your insurance companies and relatives.

Primary Physician: _____ Phone (_____)_____ Fax: (_____)_____

Urologist: _____ Phone (_____)_____ Fax: (_____)_____

Other: _____ Phone (_____)_____ Fax: (_____)_____

I authorize Dr. Krongrad and/or his staff to contact my relatives, insurance companies, physicians, and/or others listed above and/or their staff for the purpose of completing, sharing, and/or reviewing my confidential medical records and/or coordinating the administrative aspects of my care.

Signed: _____ Date: _____

THE KRONGRAD INSTITUTE

Name:_____ Date _____

Preparing For Your Laparoscopic Radical Prostatectomy

Getting ready for LRP requires several simple steps, which are outlined below. On receiving this form, please sign it and fax it to us at (305)936-0498 so what we are sure you have received it and understand it. If you have any questions, please call us immediately. We are here to help.

On scheduling surgery:

Review your medications and notify us immediately if you are taking insulin, medications for diabetes, aspirin, products containing aspirin (*e.g.,* Alka Seltzer, Anacin, Ascriptin, Bayer, Bufferin, Darvon, Ecotrin, Excedrin, Fiorinal, Norgesic, Percodan), warfarin (*e.g.,* Coumadin), ibuprofen (*e.g.,* Motrin, Advil, Nuprin), naprosyn (*e.g.,* Aleve, Anaprox, Naproxen), steroids, or other medications for pain, inflammation, arthritis, and/or colds.

Schedule an appointment with your internist (primary physician) for a preoperative medical clearance. The appointment should be 2 weeks before your LRP. At a minimum, this appointment must generate a letter to Dr. Krongrad from your internist clearing you for surgery and must include the results of a complete physical examination, Chest X-ray, EKG, and lab work: CBC, PT/PTT/INR, complete chemistry panel, and urinalysis. In many instances, you will also need to have an exercise stress test with a cardiologist – call us if you are not sure. The medical clearance and test results cannot be more than 2 weeks old at the time of your LRP; they must be in our office no later than 1 week before surgery.

- arrange payment for LRP
- transfer your original biopsy slides to our pathologist. Do not send the slides to Dr. Krongrad.

Starting one week before surgery:

- no alcohol, caffeine, or tobacco
- no Coumadin, aspirin, or products containing aspirin
- no ibuprofen, naprosyn, and arthritis and/or pain medication
- get plenty of rest

Starting two days before surgery:

- drink plenty of liquids

The day before surgery:

- no solid food
- drink plenty of clear liquids, e.g., water, soda, juice
- take your medications, except any listed above, with clear liquids
- at 10 AM, drink 1½ ounces Fleet's Phospha-Soda as instructed
- at 4 PM, drink 1½ ounces Fleet's Phospha-Soda as instructed
- take a shower and go to sleep early.
- No eating or drinking after midnight

The morning of surgery:

- take your medications, except any listed above, with sips of water
- no eating or drinking
- brush your teeth
- report to the hospital at the assigned time

I understand and accept the steps outlined above: _____ _____

signature date