



PROSTATECTOMY INFORMATION SHEET
(INFORMANT OF RESULTS OF POST PROSTATECTOMY CARE)

Name: _____ Date: _____
 Address: _____
 Telephone: _____
 Hospital: _____
 Doctor: _____

Sl. No.	Date	Time	Remarks	Signature of Doctor	Signature of Informant
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Signature of Doctor _____
Signature of Informant _____

Date _____