ACS NPCRT Prostate Cancer Screening Toolkit

The American Cancer Society National Prostate Cancer Roundtable (ACS NPCRT) assembled this digital toolkit to support practices and clinicians in implementing prostate cancer screening. Prostate cancer screening, when guided by informed decision-making and individual risk assessment, enables earlier detection and more personalized care. This toolkit presents evidence-based resources and provides guidance for clinicians on their effective use.

To get started, expand each section to explore relevant tools, guides, and templates. The sections include materials to support practices and clinicians. Resources are available for download directly from each page. You can use the materials as they are or adapt them to fit the needs of your organization or setting.

How to Use This Toolkit

Use **this overview** of the toolkit to identify where to start based on your current screening approach.

Practice Resources (Accordion; each box will open with more information)

- Screening Overview and Recommendations +
- Practice Readiness and Planning +
- EHR Integration for Screening Workflows +

Clinician Resources (Accordion; each box will open with more information)

- Prostate Cancer Screening Workflow +
- Prostate Cancer Screening Checklist +
- Screening Conversations Aid +
- Additional Clinician Resources +

Landing Page with Accordion

Prostate Cancer Screening Toolkit Overview

How to Use the Toolkit

The American Cancer Society National Prostate Cancer Roundtable (ACS NPCRT) developed a digital toolkit to help clinicians and practices implement prostate cancer screening. All resources are downloadable and can be adapted to fit your setting. Visit the digital toolkit to explore and begin planning.

If You Do Not Currently Have a Screening Program

Start with the Practice Resources section if you want to develop a program:

Screening Overview and Recommendations

Use the *Prostate Cancer Screening: What Primary Care Clinicians Need to Know* to build a foundational understanding of prostate cancer epidemiology, risk stratification, and current screening guidelines. This slide-based resource will support you in initiating informed, individualized conversations with patients about the benefits, limitations, and uncertainties of prostate cancer screening. It will also provide a broad overview of how screening fits within the larger diagnostic pathway.

Practice Readiness and Planning

Work with an internal team to evaluate your practice's current capacity to support a prostate cancer screening program. Use the *Health System Readiness Self-Assessment and Planning Guide for Prostate Cancer Screening Programs* to guide your discussion and identify strengths and areas needing additional planning or support.

EHR Integration for Screening Workflows

Work with your IT staff to coordinate the integration of prostate cancer screening and follow-up process into the EHR. Use the *EHR Integration Discussion Guide for Prostate Cancer Screening* to align on data inputs, result documentation, and ways to reduce clinician burden.

If You Already Have a Screening Program in Place

Move to the Clinician Resources section:

Prostate Cancer Screening Workflow

Use the *Prostate Cancer Screening and Diagnosis Workflow* flowchart to become familiar with different decision points for screening, evaluation of high PSA, urologist referral, and biopsy decision.

Prostate Cancer Screening Checklist

Use the *Prostate Cancer Screening Clinic Checklist* to become familiar with the key clinical steps involved in the screening encounter, from determining patient eligibility to personalizing recommendations at each stage of the screening and follow-up process.

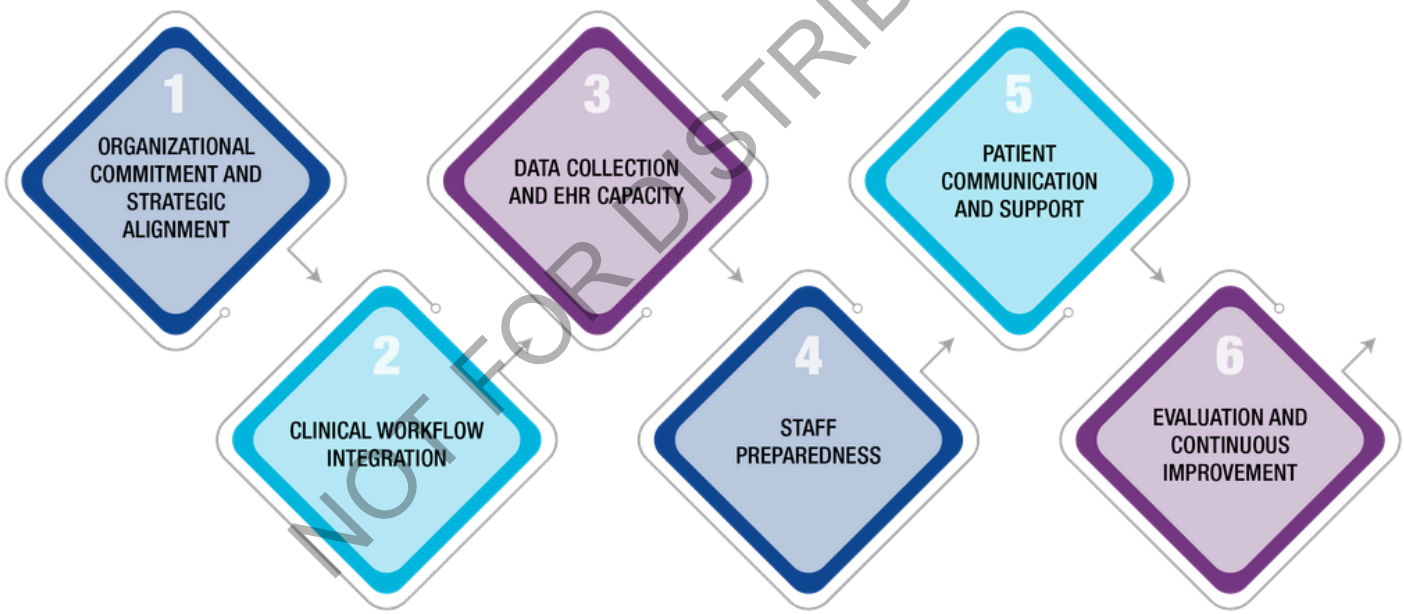
Screening Conversations Aid

Consider using the *Prostate Cancer Screening Conversations Aid* to help support clear, empathetic dialogues with patients. This resource will help you tailor conversations to different risk levels and promote informed decision-making for prostate cancer screening and follow-up.

Health System Readiness Self-Assessment and Planning Guide for Prostate Cancer Screening Programs

This resource was developed by the American Cancer Society National Prostate Cancer Roundtable to support primary care clinicians in conducting prostate cancer risk assessment and screening. This document provides a self-assessment and planning guide for your practice to begin understanding its readiness to implement a prostate cancer screening program.

See the digital toolkit for more prostate cancer screening resources.



For each of the questions that follow, enter a rating of **1 (Not in Place)**, **2 (Partially in Place)**, or **3 (Fully in Place)**, and use the "Notes / Next Steps" section to identify areas for improvement.

1 Organizational Commitment and Strategic Alignment

For each question, enter one rating by writing the number (1, 2, or 3) in the matching column to the right. Do not use a check mark.	Rating		
	1	2	3
1.1 Does the leadership team support implementing prostate cancer screening and risk assessment?			
1.2 Have prostate cancer screening and risk assessment been incorporated into a department or organizational strategic plan or quality improvement goals?			
1.3 Are there dedicated champions or staff responsible for implementation?			
1.4 Are there staff in existing programs (e.g., urology, genetic counseling) who can support integration?			
1.5 Are there data governance policies to protect the privacy and security of screening results and risk findings?			
COLUMN TOTALS (Sum the values in each column.)			

Notes / Next Steps

2 Clinical Workflow Integration

For each question, enter one rating by writing the number (1, 2, or 3) in the matching column to the right. Do not use a check mark.	Rating		
	1	2	3
2.1 Do current workflows allow time for informed decision-making conversations about screening (e.g., during wellness visits)?			
2.2 Has the workflow been tested and refined to minimize disruption to routine care and ensure feasibility across different clinic types (e.g., primary care, urology)?			
2.3 Are staff roles clearly defined for initiating, conducting, and documenting informed decision-making discussions and screening?			
2.4 Is there a system to identify and flag patients at higher risk (Black population, patients with family history, germline mutations) for earlier screening discussions?			
2.5 Is there a patient navigation process to support urology and genetic counseling referrals, MRI scheduling, and biomarker test ordering?			
2.6 Is there a follow-up system to track whether patients with elevated PSA results have completed recommended referrals, imaging, and additional testing?			
COLUMN TOTALS (Sum the values in each column.)			

Notes / Next Steps

3 Data Collection and EHR Capacity

For each question, enter one rating by writing the number (1, 2, or 3) in the matching column to the right. Do not use a check mark.		Rating		
		1	2	3
3.1	Can the EHR capture family history and risk factors (e.g., race, family history of prostate or other hereditary cancers, germline mutations)?			
3.2	Is there a process to document and retrieve informed decision-making discussions, patient decisions about screening, and PSA orders and results?			
3.3	Is there a process to document and retrieve risk assessments, MRI findings (PI-RADS scores), and biomarker test results?			
3.4	Can patient reminders for screening and follow-up alerts be automated?			
3.5	Is there a process for tracking urology and other specialty referrals initiated and completed?			
3.6	Does the EHR provide real-time, provider-facing alerts to flag missed opportunities for informed decision-making, unordered or incomplete screenings, and abnormal results?			
3.7	Are patient summary dashboards or screens available that highlight open care gaps related to prostate cancer screening and follow-up?			
3.8	Are clinical decision support rules in place to trigger screening prompts based on patient demographics (e.g., age, race, family history)?			
3.9	Does the EHR include population health modules or reports to identify screening gaps across a patient panel and support outreach to patients not recently seen?			
3.10	Can the EHR integrate or link to risk assessment tools (e.g., risk calculators like PCPT V2, ERSPC, PBCG)?			
	COLUMN TOTALS (Sum the values in each column.)			

Notes / Next Steps

4 Staff Preparedness

For each question, enter one rating by writing the number (1, 2, or 3) in the matching column to the right. Do not use a check mark.		Rating		
		1	2	3
4.1	Have clinical and non-clinical staff responsible for implementation been oriented on the rationale for the screening program and trained to conduct informed decision-making conversations about screening benefits, limitations, and uncertainties?			
4.2	Are scripts, decision aids, visuals, and handouts available and accessible?			
4.3	Are staff responsible for implementation confident in discussing PSA results, risk factors, and screening recommendations?			
4.4	Is there a referral pathway for urology and genetic counseling when needed?			
4.5	Is staff trained on how to document for billing or provide cost transparency to patients regarding PSA testing, MRI, and biomarker tests?			
	COLUMN TOTALS (Sum the values in each column.)			

Notes / Next Steps

5 Patient Communication and Support

For each question, enter one rating by writing the number (1, 2, or 3) in the matching column to the right. Do not use a check mark.		Rating		
		1	2	3
5.1	Are materials available in multiple languages and literacy levels?			
5.2	Are medical interpreters and culturally responsive practices in place?			
5.3	Are patients offered different formats to understand screening information (e.g., verbal explanations, visual aids, written materials)?			
5.4	Are patients informed about available care coordination or navigation support?			
5.5	Are resources in place to address financial barriers to screening and follow-up for uninsured or underinsured patients (e.g., coverage assistance, sliding-scale fees, charity care programs)?			
5.6	Can patients easily follow up with questions or concerns?			
5.7	Is the program designed to reduce disparities in access to screening and follow-up care for underserved or high-risk populations (e.g., Black population, patients with limited English proficiency)?			
	COLUMN TOTALS (Sum the values in each column.)			

Notes / Next Steps

6 Evaluation and Continuous Improvement

For each question, enter one rating by writing the number (1, 2, or 3) in the matching column to the right. Do not use a check mark.		Rating		
		1	2	3
6.1	Has input from patients or community members been incorporated into the design and improvement of the screening program?			
6.2	Are metrics in place to track screening rates, completion of informed decision-making discussions, and follow-up of abnormal results?			
6.3	Is feedback from clinicians and staff routinely collected and used to refine workflows, training, or tools?			
6.4	Are disparities in screening completion and follow-up being monitored and addressed (e.g., by risk, race, language, insurance status)?			
6.5	Is there a plan to review and update screening protocols and tools over time based on new guidelines?			
	COLUMN TOTALS (Sum the values in each column.)			

Notes / Next Steps

Self-Assessment Averages and Interpretation

After completing the sections above, record your column totals in the table below. Calculate the Total Score by summing the column totals. Then divide the Total Score by the number of questions to calculate the average. Refer to the last table to interpret your results and guide next steps.

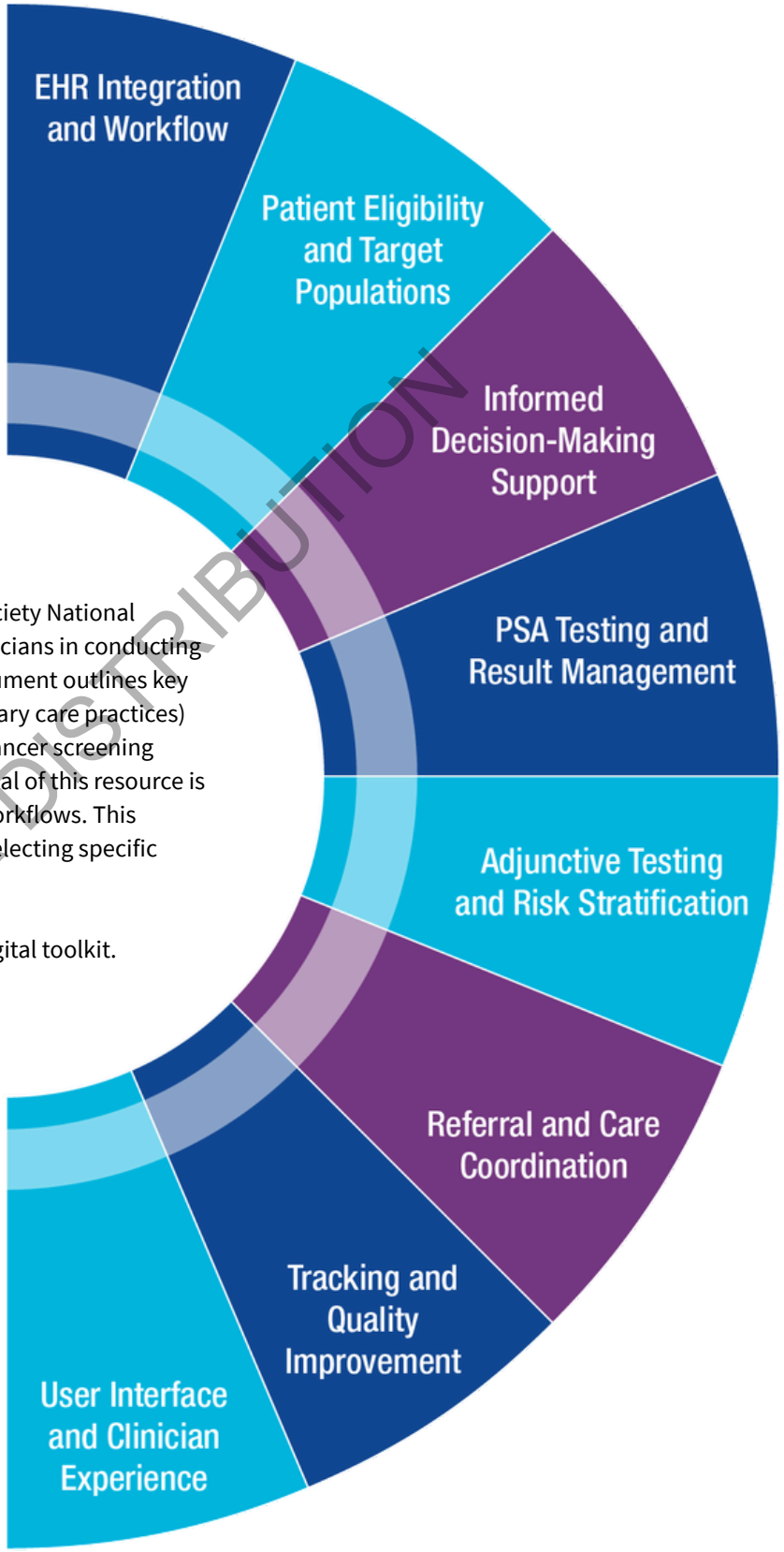
Assessment Category	Column Totals			Total Score (Sum column totals)	Average Score (Total ÷ # Questions)
	1	2	3		
1 Organizational Commitment and Strategic Alignment (5 Questions)					
2 Clinical Workflow Integration (6 Questions)					
3 Data Collection and EHR Capacity (10 Questions)					
4 Staff Preparedness (5 Questions)					
5 Patient Communication and Support (7 Questions)					
6 Evaluation and Continuous Improvement (5 Questions)					

Average Scores	Interpretation	Suggested Actions
1–1.9	Early Stages	Prioritize this area for planning and support. Consider leadership engagement, technical assistance, additional staff, training, and workflow adaptations or modifications.
2–2.5	Developing	Identify specific items rated 1 or 2 and develop a plan to strengthen them.
2.6–3	Strong Foundation	Maintain current practices and consider using this category as a model for areas needing improvement. Continue monitoring for updates or refinements.

References

1. Caci L, Nyantakyi E, Blum K, et al. Organizational readiness for change: A systematic review of the healthcare literature. Implement Res Pract. 2025;6:26334895251334536. Published 2025 May 15. doi:10.1177/26334895251334536.
2. McClam M, Workman L, Walker TJ, et al. Organizational readiness for implementation: A qualitative assessment to explain survey responses. BMC Health Serv Res. 2025;25(1). doi:10.1186/s12913-024-12149-8.

EHR Integration Discussion Guide for Prostate Cancer Screening



This resource was developed by the American Cancer Society National Prostate Cancer Roundtable to support primary care clinicians in conducting prostate cancer risk assessment and screening. This document outlines key considerations for practices (e.g., urology practices, primary care practices) and IT departments collaborating to integrate prostate cancer screening workflows into the electronic health record (EHR). The goal of this resource is to support implementation without disrupting clinical workflows. This discussion guide can be used as a whole or adapted by selecting specific sections that best suit the needs of your practice.

For more prostate cancer screening resources, see the digital toolkit.

EHR Integration and Workflow

- [ ] Discuss how prostate cancer screening will be integrated into the EHR (e.g., PSA order sets, clinical decision support alerts, embedded risk stratification modules).
- [ ] Identify key points in the clinical workflow where screening should be triggered (e.g., annual wellness visits for eligible patients, specific clinical manifestations, high PSA level follow-up).
- [ ] Determine how the system will identify and flag high-risk patients (Black population, those with family history, germline mutations).
- [ ] Determine how and where informed decision-making discussions and screening decisions will be documented and stored in the EHR.

Patient Eligibility and Target Populations

- [ ] Review the age ranges for initiating screening discussions (40-45 years for high-risk patients, 45-50 years for average-risk patients).
- [ ] Discuss criteria for identifying high-risk populations, including Black population, patients with a strong family history of prostate cancer, patients with a family history of hereditary breast and ovarian cancer syndrome or Lynch syndrome, and patients with germline mutations (e.g., BRCA2, MSH2, MSH6).
- [ ] Establish criteria for personalizing screening frequency based on age, PSA level, risk factors, and life expectancy.
- [ ] Confirm when screening should be discontinued (e.g., patients ≥70 years, patients with life expectancy <10 years).

Informed Decision-Making Support

- [ ] Determine how the EHR will support informed decision-making conversations (e.g., embedded decision aids, patient education materials, documentation templates).
- [ ] Discuss options for patient-facing outputs or printouts that explain PSA screening benefits, harms, and uncertainties to support discussions.
- [ ] Establish standard documentation for informed decision-making discussions, including patient understanding, questions addressed, and patient decision regarding screening.
- [ ] Review culturally appropriate materials available in multiple languages to support diverse patient populations.

PSA Testing and Result Management

- [ ] Identify the clinical data needed for PSA result interpretation (e.g., age, race, prior PSA values, family history).
- [ ] Establish thresholds and age-specific reference ranges for flagging elevated PSA results that warrant clinical action.
- [ ] Determine clinical decision support for next steps after elevated PSA (e.g., confirmatory PSA, MRI, biomarker testing, risk assessment, urology referral).
- [ ] Create workflows for communicating PSA results to patients, including normal results and elevated results requiring follow-up.

Adjunctive Testing and Risk Stratification

- [ ] Review available adjunctive tests for risk refinement, including prostate MRI (with PI-RADS scoring), biomarker testing (urine and serum), and risk calculators.
- [ ] Establish criteria for MRI ordering.
- [ ] Establish criteria for when biomarker testing should be considered.
- [ ] Discuss integration of risk calculator tools and when they should be used in the clinical workflow.
- [ ] Clarify licensing requirements, usage restrictions, and costs for selected risk calculators and biomarker tests. Consider freely available tools (e.g., PCPT V2, ERSPC, PBCG) versus proprietary options.
- [ ] Determine how MRI (PI-RADS scores), risk level, and biomarker results will be documented and incorporated into biopsy decision-making.

Referral and Care Coordination

- [ ] Establish clear criteria and workflows for urology referrals (e.g., PSA above agreed-upon thresholds, significant change in PSA level, persistently elevated PSA, abnormal MRI findings, patient preference for specialist consultation).
- [ ] Determine criteria for genetic counseling referrals (e.g., patients with family history suggestive of hereditary cancer, known or suspected cancer susceptibility genes).
- [ ] Create mechanisms for tracking referrals and ensuring appropriate follow-up of abnormal screening results.
- [ ] Establish communication pathways between primary care and specialist clinicians for coordinated patient care.

Example Scenario

A 52-year-old man presents for his annual wellness visit. During the risk assessment discussion, he reports that his father was diagnosed with prostate cancer at age 57, which identifies him as having a family history risk factor.

The clinician uses an embedded decision aid to guide an informed decision-making conversation about screening benefits, limitations, and uncertainties. The patient decides to proceed with screening. His PSA result returns at 4.2 ng/mL (elevated for age). The EHR triggers a clinical decision support alert recommending confirmatory PSA testing and consideration of prostate MRI.

After confirmatory testing shows persistent elevation at 4.5 ng/mL, an MRI is ordered showing a PI-RADS 4 lesion in the peripheral zone. Based on these results and the risk calculator assessment showing 28% risk of clinically significant cancer, the patient is referred to urology for biopsy consideration. The EHR documents all informed decision-making discussions, test results, and care coordination steps, ensuring continuity of care.

Tracking and Quality Improvement

- [ ] Determine how screening activities will be tracked within the EHR for quality monitoring (e.g., screening rates by age and risk group, informed decision-making documentation rates).
- [ ] Define metrics for success, including screening completion rates in eligible populations, appropriate screening in high-risk groups, follow-up rates for abnormal results, referral completion rates, time to follow-up, and abnormal result resolution.
- [ ] Establish closed-loop tracking mechanisms for identifying patients overdue for screening, lost to follow-up, or with unresolved abnormal findings.
- [ ] Create reports to monitor equity in screening access, referral completion, time to follow-up, and resolution of abnormal results across different patient populations (race, ethnicity, socioeconomic status).

User Interface and Clinician Experience

- [ ] Review whether screening workflows are user-friendly for clinicians and feasible to use during visits.
- [ ] Establish a reasonable target duration for informed decision-making discussions, and ensure system design minimizes documentation burden.
- [ ] Provide training and support materials for clinicians on using EHR tools for prostate cancer screening.
- [ ] Gather clinician feedback on workflow efficiency and identify opportunities for improvement.

EHR Integration Action Plan

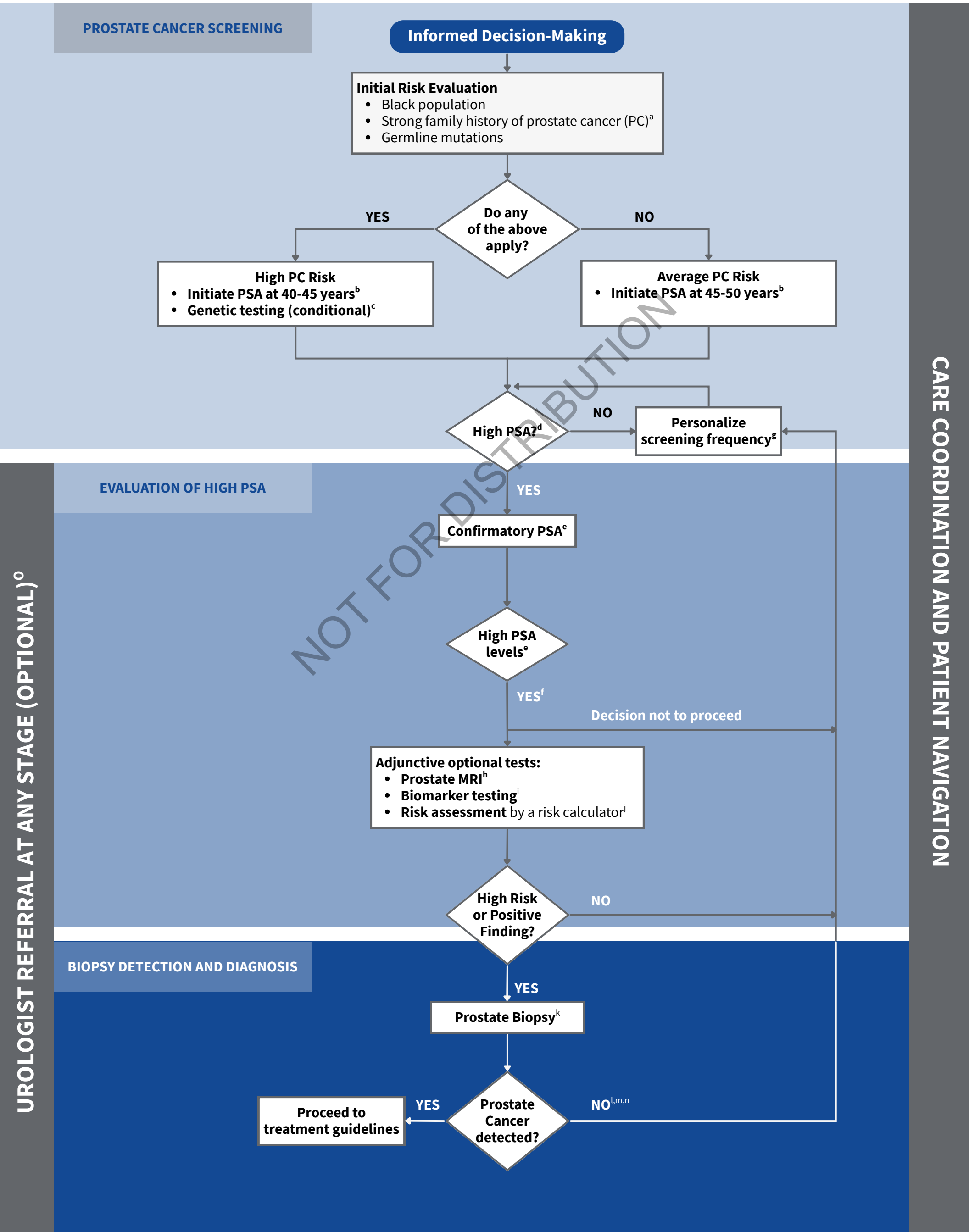
Goal: Support prostate cancer screening implementation without disrupting clinical workflows.

Topic	Action Steps	Person/Team Responsible	Resources Needed	Timeline
EHR Integration and Workflow				
Patient Eligibility and Target Populations				
Informed Decision-Making Support				
PSA Testing and Result Management				
Adjunctive Testing and Risk Stratification				
Referral and Care Coordination				
Tracking and Quality Improvement				
User Interface and Clinician Experience				

Prostate Cancer Screening and Diagnosis Workflow

This resource was developed by the American Cancer Society National Prostate Cancer Roundtable to support primary care clinicians in conducting prostate cancer screening. This flowchart illustrates a typical clinic workflow for prostate cancer screening and follow-up, highlighting key decision points around risk assessment, screening, evaluation of high PSA, urologist referral, and biopsy decision. The screening goal is the detection of clinically significant prostate cancer [Grade Group 2 or higher (GG2+)].[1]

See the digital toolkit [This will be hyperlinked when we have the website link] for more prostate cancer screening resources.



Footnotes

a Patients with a strong family history of PC should ideally be genotyped to determine whether this is associated with a pathogenic variant.[1]

b The United States Preventive Services Task Force (USPSTF) recommends individualized decision-making for patients aged 55–69 years (Grade C).[2]

c Patients with a family history suggestive of hereditary cancer should undergo genetic testing. If there is a known or suspected cancer susceptibility gene, referral to a cancer genetic counselor may be considered.

d Increased PSA is based on laboratory, prostate size, and age median values.[1]

e Consider DRE as an optional complementary test.

f Informed decision making should accompany the biopsy decision. Patients should be advised that a biopsy may detect low-mortality prostate cancers that can be safely managed with active surveillance rather than immediate treatment.

g Clinicians may repeat PSA every 2-4 years (ages 50-69), personalize the screening frequency, or decide to discontinue screening, based on patient preference, age, PSA, prostate cancer risk, life expectancy, and general health following SDM.[1] Patients with no high-risk factors may lengthen the rescreening interval or discontinue screening based on SDM.[1] The USPSTF advises against PSA screening in patients ≥70 years (Grade D).[2]

h Evidence shows that mpMRI improves detection of clinically significant prostate cancer while reducing identification of non-significant disease, an effect especially notable after a prior negative biopsy.[3] We recommend an mpMRI to aid biopsy decision.

i Urine and serum biomarkers may be used for further risk stratification when the results could influence the decision to perform a biopsy, typically in patients with a PSA between 2.5 ng/mL and 10 ng/mL and no clinical or laboratory data suggesting clear low or high-risk disease.[3]

j Some tools are used to calculate the risk of clinically significant prostate cancer (GG2+). Risk calculators may include PSA, %free PSA, other biomarkers, PI-RADS, DRE, age, race, and family history, among other features. The AUA/SUO guidelines recommend: PCPT V2 (https://riskcalc.org/PCPTRC/), Chun (There is no publicly available online calculator for Chun), ERSPC (https://www.prostatecancer-riskcalculator.com/assess-your-risk-of-prostate-cancer), and PBCG (https://riskcalc.org/PBCG/).[3] After a negative biopsy result, risk calculators incorporating biopsy results should be used.[3]

k MRI-guided biopsy approach: Patients with PI-RADS 1-2 and high risk undergo systematic biopsy; PI-RADS ≥3 lesions receive targeted biopsy with optional systematic sampling.

l Further evaluation may be warranted for multifocal high-grade prostatic intraepithelial neoplasia (HGPIN), atypical small acinar proliferation (ASAP), or atypical intraductal proliferation (AIP), whereas isolated focal HGPIN does not require immediate repeat biopsy.[3]

m Screening should not be stopped solely after a negative biopsy.[3]

n PSA alone should not guide repeat biopsy decisions. Risk calculators incorporating PSA, %free PSA, PSA density, age, race, family history, and prior biopsy/MRI may aid in risk assessment.

o Referral thresholds and workflows are system-dependent and should align with local urology capacity and practice agreements.

Abbreviations

- **PC:** prostate cancer
- **PSA:** prostate-specific antigen
- **DRE:** digital rectal examination
- **MRI:** Magnetic Resonance Imaging
- **mpMRI:** Multiparametric MRI

Sources

1. Wei JT, Barocas D, Carlsson S, et al. Early Detection of Prostate Cancer: AUA/SUO Guideline Part I: Prostate Cancer Screening. J Urol. 2023;210(1):46-53. doi:10.1097/JU.0000000000003491
2. US Preventive Services Task Force.Screening for prostate cancer: US Preventive Services Task Force recommendation statement. JAMA. 2018;319(18):1901-1913. doi:10.1001/jama.2018.3710
3. Wei JT, Barocas D, Carlsson S, et al. Early Detection of Prostate Cancer: AUA/SUO Guideline Part II: Considerations for a Prostate Biopsy. J Urol. 2023;210(1):54-63. doi:10.1097/JU.0000000000003492.

Note: AUA/SUO 2026 updates were considered for the flowchart. Lin DW, Carlsson S, Filson CP, et al. Updates to Early Detection of Prostate Cancer: AUA/SUO Guideline (2026).

Prostate Cancer Screening Clinic Checklist

This resource was developed by the American Cancer Society National Prostate Cancer Roundtable to support clinicians in conducting prostate cancer screening. The document outlines key steps and considerations for clinicians at different stages of the screening process and follow-up.

1 Determine Patient Eligibility

- [ ] Patient with a prostate
- [ ] Age ≥40 years (to be adjusted according to risk factor)
- [ ] Life expectancy ≥10 years

2 Informed Decision-Making: Introduce Prostate Cancer Screening

- [ ] Use a script, visuals, or handouts as needed
- [ ] Discuss the purpose of screening and the value of an initial risk assessment
- [ ] Emphasize that screening relies on PSA testing rather than DRE, and that increased PSA levels don't equal a prostate cancer diagnosis
- [ ] Review the benefits and potential harms of prostate cancer screening
- [ ] Assess patient values and preferences
- [ ] Ensure to integrate care coordination and patient navigation across all the screening and follow-up journey
- [ ] Document patient decision

3

Assess the Patient's Risk Factors and Clinical Status

- [ ] Record age, race, and ethnicity
- [ ] Ask about family history of prostate and other related cancers
- [ ] Inquire about personal and first-degree relative history of hereditary cancer mutations (e.g., BRCA1/2)
- [ ] Question about personal or first-degree relative history of prostate cancer-associated genetic syndromes (e.g., Lynch Syndrome)
- [ ] Register prior PSA testing or prostate biopsy if have done
- [ ] Record comorbidities affecting screening benefit
- [ ] Based on history, classify the patient as high or average risk

4

Share Risk Level and Tailor Guidance

- [ ] Explain the patient's risk level and implications for screening
- [ ] Personalize screening (PSA test indication) according to age and risk
- [ ] Address concerns or misconceptions
- [ ] Refer to a genetic counselor if needed
- [ ] Provide educational materials and follow-up contact information
- [ ] Document the discussion and recommendations

5 Post-PSA Risk Stratification

- [ ] Discuss PSA results and implications with your patient
- [ ] Low PSA – continue with routine follow-up per guideline interval according to patient risk and age
- [ ] Elevated PSA – order a confirmatory PSA test
- [ ] Review family and personal history regularly for change
- [ ] Adjust screening interval based on evolving risk
- [ ] Document the discussion and recommendations

6 Next Clinical Steps if High PSA is Confirmed

- [ ] Conduct informed decision-making for prostate biopsy
- [ ] Explain that the decision to proceed to biopsy is informed by combined risk assessment rather than PSA alone
- [ ] Include information about the possibility of active surveillance or treatment in case of positive results
- [ ] Consider referral to a urologist or ordering adjunctive optional tests to refine risk and inform biopsy decisions (prostate MRI, biomarker testing, and/or risk assessment by a risk calculator). Note: Referral thresholds and workflows are system-dependent and should align with local urology capacity and practice agreements.
- [ ] Explain that screening is not discontinued solely due to a negative biopsy
- [ ] Document personalized recommendations

References

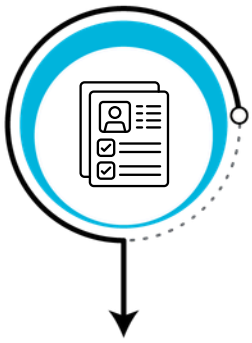
1. US Preventive Services Task Force. Screening for prostate cancer: US Preventive Services Task Force recommendation statement. JAMA. 2018;319(18):1901-1913. doi:10.1001/jama.2018.3710
2. Wei JT, Barocas D, Carlsson S, et al. Early Detection of Prostate Cancer: AUA/SUO Guideline Part I: Prostate Cancer Screening. J Urol. 2023;210(1):46-53. doi:10.1097/JU.0000000000003491
3. Wei JT, Barocas D, Carlsson S, et al. Early Detection of Prostate Cancer: AUA/SUO Guideline Part II: Considerations for a Prostate Biopsy. J Urol. 2023;210(1):54-63. doi:10.1097/JU.0000000000003492
4. Wolf AM., Wender RC, Etzoni RB, et al. American Cancer Society guideline for the early detection of prostate cancer: Update 2010. Ca Cancer J Clin. 2010;60:70-98.
5. Lin DW, Carlsson S, Filson CP, et al. Updates to Early Detection of Prostate Cancer: AUA/SUO Guideline (2026).

Prostate Cancer Screening Conversations Aid

This resource was developed by the American Cancer Society National Prostate Cancer Roundtable to support primary care clinicians in conducting prostate cancer risk assessment and screening. This document includes best practices and discussion aids for talking with patients about prostate cancer screening. Each discussion aid is tailored to a different scenario based on timing, screening decisions, patient risk, and test results. These are flexible talking points designed to guide conversations, not to be read verbatim. Clinicians should adapt the language and content to fit each patient's individual needs, health literacy level, and clinical context.

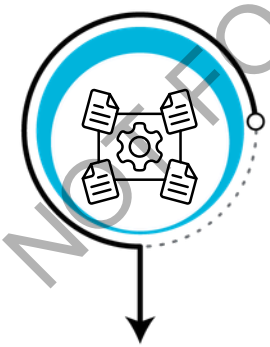
See the digital toolkit for more prostate cancer screening resources.

Best Practices for Talking to Patients About Making a Decision to Initiate Prostate Cancer Screening



TAILOR INFORMATION TO EACH PATIENT

Use clear, accessible language appropriate for different health literacy levels. Provide materials in multiple languages and use a medical interpreter when needed to ensure understanding.

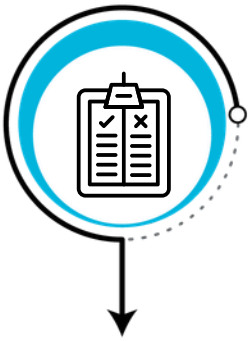


PRESENT INFORMATION IN MULTIPLE FORMATS

Combine numbers and descriptions (quantitative and qualitative information) and use both verbal explanations and a handout to help patients understand screening benefits, limitations, and potential outcomes.

BE CULTURALLY SENSITIVE AND EMPATHETIC

Show cultural competence in all communications, particularly when discussing sensitive topics related to prostate health, sexuality, and masculinity. Be respectful of diverse backgrounds and health beliefs.



DISCUSS BOTH BENEFITS AND LIMITATIONS

Clearly explain the potential advantages of early detection as well as the possibilities of overdiagnosis, overtreatment, and procedure-related complications. Help patients understand the uncertainty involved in screening decisions.

ENCOURAGE QUESTIONS AND ONGOING DIALOGUE

Create space for patients to ask questions during the appointment and provide clear ways for them to contact you or other healthcare professionals with additional questions after they leave. Document all informed decision-making discussions.

Discussion Aids for Talking With Patients About Prostate Cancer Screening

1 Discussing Prostate Cancer Screening and Informed Decision-Making

I'd like to talk with you about prostate cancer screening. Prostate cancer is relatively common, and we have a blood test called PSA that can help catch it early, when it's most treatable. You may have heard different things about PSA screening over the years, but guidelines have evolved, and I'd like to go over where things stand today and what the test can and cannot tell us. Like any screening test, it has limitations that are important to understand.

PSA levels can be high for reasons other than cancer, like an enlarged prostate or inflammation, and occasionally a PSA can be normal even when cancer is present. It's not a yes-or-no answer on its own, but it helps us identify who may need closer follow-up. That's why we use additional tests when needed before making any decisions.

If you're open to it, the next step would be to look at your individual history to help us decide whether screening makes sense, when to start, and how often to repeat it. We can then decide together what feels right for you.

Assess the patient's risk factors and clinical status

If patient is at average risk

For patients like you, who are not at higher risk of having prostate cancer, we typically recommend starting screening between ages 45 and 50.

If patient is at high risk

Based on your [Black population/family history/genetic mutation], you have a higher risk of prostate cancer. For patients at higher risk, we typically recommend starting screening earlier, around ages 40 to 45, and screening more frequently.

Given what we talked about, would you like to proceed with the next steps? Do you have any questions or concerns I can address?

2 Discussing Normal PSA Results

Your PSA test result came back at [value] ng/mL, which is within the normal range for your age. This is reassuring. Based on this result and your overall risk, I recommend continuing screening every [1-4] years. Please let me know if you develop any new symptoms or if there are changes in your family history, since these could affect your screening plan.

Do you have any questions about these results or what we discussed?

3 Discussing Elevated PSA Results

Your PSA test result came back at [value] ng/mL, which is higher than expected for your age. I'd like to talk about what this means and what our next steps might be. It's important to understand that an elevated PSA does not mean you have cancer. PSA levels can be elevated for other reasons.

The next step is to repeat the PSA test to confirm the result. If the PSA level remains high, we have several options to better understand what may be causing it. These can include additional tests, such as an MRI or biomarker tests, or referral to a urologist to determine whether further evaluation, including a biopsy, is needed. A biopsy may be recommended depending on these results and your individual situation.

I want to emphasize that if a biopsy is eventually needed, it may detect low-risk cancers that we can safely monitor rather than treat immediately. This allows us to follow the cancer closely and only treat it if there are signs of progression.

What questions do you have about the next steps?

You can always reach me at [your contact] if you think of additional questions before your next appointment.

4 Discussing Confirmatory PSA Results

[If PSA levels are normal:] We received your repeat PSA result of [value] ng/mL. This result is within the normal range for your age, which is reassuring. Based on this, I'd recommend repeating your PSA in [X] years. Please let me know if you develop any new symptoms or if there are any changes in your family history, since these could affect your screening plan.

[If increased PSA levels are confirmed:] We received your repeat PSA result of [value] ng/mL. This confirms that your PSA remains elevated, which means we should investigate further.

Option 1: Recommending adjunctive testing	**Option 2: Offering urology referral**
Before deciding whether a biopsy is necessary, I'd like to do some additional tests. A prostate MRI or biomarker tests can help us better understand whether there's a higher likelihood of cancer that would need treatment and help guide us on whether a biopsy is really necessary. What questions do you have?	At this point, I'd like to refer you to a urologist – a specialist in prostate health who can guide the next steps. This may include additional testing and a decision about whether a biopsy is needed. I'll stay involved in your care throughout this process, so please don't hesitate to reach out if you have questions or concerns along the way. What are your thoughts?

5 Discussing Low Risk of Positive Finding

[If additional testing was ordered after a confirmed high PSA result:] Your [MRI/biomarker test] results are in. These results suggest a low risk of cancer that would require treatment.

Based on these findings, I recommend continuing to monitor your PSA levels regularly without moving to a biopsy at this time. We'll follow this with repeat testing every [timeframe], and if anything changes, we can reassess together. Staying on this monitoring plan helps us catch any meaningful changes early.

It's also important to keep me informed of any new symptoms or changes in your health. What questions do you have about these results and our monitoring plan?

6 Discussing High Risk of Positive Finding and Biopsy Decision

[If additional testing was ordered after confirming elevated PSA:] Your [MRI/biomarker test/Risk assessment] results are in. These results suggest that if cancer is present, it's more likely to be the type that would need treatment.

I'd recommend discussing a prostate biopsy. A biopsy involves taking small tissue samples from the prostate to check for cancer and is usually performed by a urologist. It's generally safe, and I want you to know what to expect.

The most common issue is infection, which can sometimes require treatment or a hospital visit. For a short time, some patients might notice blood in their urine, stool, or semen. Some patients also have trouble urinating or experience pain. Rarely, there can be effects on sexual function. Most side effects resolve on their own, but it's important to be aware of them.

It's also important to understand what the results could mean. Not all prostate cancers need immediate treatment. If we find a low-risk cancer, I may recommend close monitoring with regular PSA tests, MRIs, and biopsies if needed, and only treat if it shows signs of progression. This approach can help avoid unnecessary treatment and side effects. If needed, we will talk through treatment options.

[If urologist referral recommended at this step:] I'd like to refer you to a urologist who specializes in prostate biopsies and can go over this in more detail. They'll be able to answer specific questions about the procedure and coordinate the next steps. I'll stay involved in your care throughout this process, so please don't hesitate to reach out if questions come up.

Given what we talked about, how are you feeling about moving forward? What questions can I answer to help you decide?

References

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