

# CONFIDENTIAL PHYSICIAN CANCER REPORTING FORM

(Please complete all sections and correct any inaccurate printed information)

PHYSICIAN NAME	PHONE	LICENSE
REFERENCE SOURCE		

## PATIENT INFORMATION

NAME	SSN	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS AT DIAGNOSIS (include zip code)	DATE OF BIRTH	MARITAL STATUS
	RACE/ETHNICITY	
PHONE	INSURANCE	LONGEST HELD OCCUPATION
VITAL STATUS: <input type="checkbox"/> ALIVE <input type="checkbox"/> DEAD	DATE OF LAST CONTACT OR DEATH	PLACE OF DEATH

## CANCER DIAGNOSIS

PRIMARY SITE	LATERALITY <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	HISTOLOGY
STAGE AT DIAGNOSIS	DATE OF DIAGNOSIS	CURRENT CANCER STATUS <input type="checkbox"/> FREE <input type="checkbox"/> NOT FREE <input type="checkbox"/> UNKNOWN

## DIAGNOSTIC WORK-UP AT TIME OF DIAGNOSIS

Please record any pertinent findings regarding the location, size and extent of tumor at time of diagnosis.

PHYSICAL FINDINGS	DATE	
X-RAY/SCANS/SCOPIC FINDINGS (OR ATTACH COPIES OF REPORTS)	DATE	
PATHOLOGY FINDINGS (OR ATTACH COPY OF REPORTS)	DATE	
PSA LEVEL (PRE-BX, PROSTATE CA ONLY)	ERA/PRA (BREAST ONLY)	DATE
BIOPSY SITE <input type="checkbox"/> INCISIONAL <input type="checkbox"/> EXCISIONAL <input type="checkbox"/> OTHER: _____	DATE	

## TREATMENT AT TIME OF DIAGNOSIS

SURGICAL TREATMENT: <input type="checkbox"/> SHAVE/PUNCH BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> WIDE/RE-EXCISION <input type="checkbox"/> ORCHIECTOMY <input type="checkbox"/> TURP <input type="checkbox"/> TURBT <input type="checkbox"/> POLYPECTOMY <input type="checkbox"/> LASER ABLATION/CRYOSURGERY <input type="checkbox"/> OTHER:	
FACILITY	DATE
TUMOR SIZE AND LOCATION OF TUMOR (FOR MELANOMA RECORD CLARK'S AND DEPTH OF INVASION)	
RADIATION THERAPY: SITES TREATED	DATE STARTED
FACILITY	TOTAL cGy
DRUG TREATMENT: <input type="checkbox"/> CHEMOTHERAPY <input type="checkbox"/> HORMONE THERAPY <input type="checkbox"/> IMMUNOTHERAPY	OTHER TREATMENT
AGENTS (SPECIFY)	DATE STARTED
REFERRAL TO HOSPITAL OR OTHER PHYSICIAN FOR THIS CANCER? <input type="checkbox"/> YES <input type="checkbox"/> NO	MD NAME AND ADDRESS
IF ADMITTED, HOSPITAL NAME AND ADDRESS	DATE OF ADMISSION
NAME OF PERSON COMPLETING FORM	PHONE

PLEASE RETURN COMPLETED FORM TO: