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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: ☐ MALE ☐ FEMALE
ADDRESS AT DIAGNOSIS (include zip code)	DATE OF BIRTH	MARITAL STATUS
	RACE/ETHNICITY	
PHONE	INSURANCE	LONGEST HELD OCCUPATION
VITAL STATUS: ☐ ALIVE ☐ DEAD	DATE OF LAST CONTACT OR DEATH	PLACE OF DEATH

CANCER DIAGNOSIS

PRIMARY SITE	LATERALITY ☐ RIGHT ☐ LEFT	HISTOLOGY
STAGE AT DIAGNOSIS	DATE OF DIAGNOSIS	CURRENT CANCER STATUS ☐ FREE ☐ NOT FREE ☐ 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 ☐ INCISIONAL ☐ EXCISIONAL ☐ OTHER: _____		DATE

TREATMENT AT TIME OF DIAGNOSIS

SURGICAL TREATMENT: ☐ SHAVE/PUNCH BX ☐ EXCISIONAL BX ☐ WIDE/RE-EXCISION ☐ ORCHIECTOMY ☐ TURP ☐ TURBT ☐ POLYPECTOMY ☐ LASER ABLATION/CRYOSURGERY ☐ OTHER:

FACILITY	DATE

Include the pathology report diagnosing this cancer, if available, when submitting this form to the registry. If patient was referred for treatment elsewhere, please indicate the name of the MD or hospital the patient was sent.

DRUG TREATMENT: ☐ CHEMOTHERAPY ☐ HORMONE THERAPY ☑ IMMUNOTHERAPY	OTHER TREATMENT
AGENTS (SPECIFY)	DATE STARTED

REFERRAL TO HOSPITAL OR OTHER PHYSICIAN FOR THIS CANCER? ☐ YES ☐ 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:

Cancer Registry of Greater California - Data Collection Unit
1750 Howe Ave, Suite 550, Sacramento, CA 95825
Tel: (916) 779-0275 Data Collection Manager
Confidential Fax: (916) 564-9300
www.crgc-cancer.org