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| CONFIDENTIAL PHYSICIAN CANCER REPORTING FORM(*Please complete all sections*)Please Return Completed Form to: Cancer Registry of Greater CA, 1825 Bell St, 102, Sacramento, CA 95825 or **Confidential Fax: 916-564-9300** |
| PHYSICIAN NAME: |  | **PHONE NUMBER:** |
| **REFERENCE SOURCE:** |  | **LICENSE #:** |
|  |
| PATIENT INFORMATION |
| **NAME:** |  | **SSN:** |
| **ADDRESS AT DIAGNOSIS** **(include zip code):** |  | **DATE OF BIRTH:** |
| **PHONE NUMBER:** |  | **MARITAL STATUS:** |
| **VITAL STATUS:**  | **□ Alive □ Dead**  | **SEX: □ Male □ Female** |
| **DATE OF LAST CONTACT OR DEATH:** |  | **Race/Ethnicity:** |
| **PLACE OF BIRTH:** |  | **LONGEST HELD OCCUPATION:** |
| **INSURANCE:** |  |
|  |
| 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-RAYS/SCANS/SCOPIC FINDINGS (or attach copy of reports):** | **DATE:** |
| **PATHOLOGY FINDINGS (or attach copy of reports):** | **DATE:** |
| **PSA LEVEL (Pre-BX, Prostate CA 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****□ LASER ABLATION/CRYOSURGERY****□ POLYPECTOMY** | **□ 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**: **□** Chemotherapy □ Hormone Therapy □ Immunotherapy | **Other Treatment**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **AGENTS (Specify):** | **Date Started**: |
| **REFERRAL TO HOSPITAL OR** □ YES**OTHER PHYSICIAN FOR THIS CANCER:** □ NO | **PHYSICIAN NAME & ADDRESS:** |
| **IF ADMITTED, HOSPITAL NAME AND ADDRESS:** |  |
| **NAME OF PERSON COMPLETING FORM:** | **PHONE:**  |