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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:** | | | | |