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 OTHER PHYSICIAN FOR THIS CANCER: ☐ YES ☐ NO		**PHYSICIAN NAME & ADDRESS:**			
IF ADMITTED, HOSPITAL NAME AND ADDRESS:					
NAME OF PERSON COMPLETING FORM:				**PHONE:**	