NEVADA CENTRAL CANCER REGISTRY

4126 Technology Way, Suite 200, Carson City, NV, 89706 Phone: 775-684-5968 Fax: 775-684-5999

MEDICAL ONCOLOGY REPORTING FORM

Reporting Facility Name:	**NPI:**
Reporting Physician Name:	**NPI:**
Address:	

City:	**State:**	**Zip:**	**Phone:**
Referred <u>from</u> Hospital or other Physician for this cancer? ☐ Yes ☐ No	Hospital Name:		
	Physician Name:		

PATIENT DEMOGRAPHIC INFORMATION

Patient's Last Name:	**First:**	**Middle:**	**Maiden:**
SSN:	**DOB:**	**Birth State:**	**Birth Country:** ☐ USA ☐ Unknown ☐ Other:

Sex: ☐ Male ☐ Female ☐ Other _____ **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Payer: ☐ Insured ☐ Not Insured ☐ Medicaid ☐ Medicare ☐ Self-Pay ☐ VA ☐ Military ☐ Indian/Public Health Services

Race (*Mark all that apply*)**:** ☐ White ☐ African American ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Other _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Address Street:	**City:**	**State:**	**Zip:**

Occupation:	**Industry:**	**Date of Last Contact:**	**Vital Status:** ☐ Dead ☐ Alive Evidence of Tumor: ☐ Yes ☐ No

CANCER AND STAGING INFORMATION

Date of Diagnosis:	**Tumor Site:**	**Laterality:** ☐ Right ☐ Left ☐ Both ☐ Unknown	**Tumor Size (*Millimeters*):**	**Histology (*Type of cancer*):**

Diagnostic Confirmation: ☐ Histology ☐ Cytology ☐ Microscopic ☐ Lab test ☐ Visual ☐ X-ray ☐ Clinical ☐ Unknown

TNM Staging: ☐ Clinical ☐ Pathological ☐ Unknown

T _____ N _____ M _____ Stage Group _____

Please attach copies of surgical or pathology report if necessary

TREATMENT INFORMATION (*MARK ALL THAT APPLY*)

Surgery: ☐ Yes ☐ No ☐ Unknown	Procedure Name:	Date:
Chemotherapy: ☐ Yes ☐ No ☐ Unknown	Agents, duration:	Date Started:
Radiation: ☐ Yes ☐ No ☐ Unknown	Modality Type, Volume, and Number of Treatments:	Date Started: Date Ended:
Hormone/Other Therapy: ☐ Yes ☐ No ☐ Unknown	Type, duration:	Date Started:

Please FAX or MAIL completed form and supporting documents to the number/address listed at the top of the form