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
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 / MD NAME AND ADDRESS	
IF ADMITTED, HOSPITAL NAME AND ADDRESS	DATE OF ADMISSION
NAME OF PERSON COMPLETING FORM	PHONE

PLEASE RETURN COMPLETED FORM TO: