

Arkansas Central Cancer Registry / Arkansas Department of Health
Patient Reporting Form

Reporting Facility Name: _____ Person completing Form: _____

1. Name: _____
Last First Middle

2. Address: _____ 3. Gender: *Male Female*
Street City State Zip Code

4. DOB: (mm/dd/yyyy) _____ 5. Social Security # _____ 6. Phone number: () _____ - _____

7. Occupation: _____ 8. Race: *white Af. Am. Hispanic Other (please specify)* _____

9. Primary Payer (circle one): *com/private Medicare w/supple Medicare w/o supple Medicaid self pay not insured Unknown*

10. Tobacco Use: *yes no past unk* 11. Alcohol Use: *yes no past unk* 12. Family Hx of cancer: *yes No Unk*

13. Is this a new cancer or a recurrence of a previously diagnosed cancer? (Check one) *New* ____ *Recurrence* ____

14. Procedures Performed:

Biopsy: _____ FNA: _____ BM Asp: _____ Date of Procedure: _____

Surgical Procedure Type: _____ Date of Procedure: _____

15. Primary Cancer site: _____ 16. Diagnosis Date _____ 17. Paired Organ (left/right/bilateral): _____

18. Tumor Size: _____ 19. Histology (cell type): _____

20. Grade (circle one): *well, moderate or poorly differentiated* 21. Lymph nodes removed (# positive / # removed): _____

22. Pre op Tumor Markers (circle one and add value) Prostate (PSA/PAP) _____ Breast (ERA/PRA) _____ / _____
Liver (AFP) _____ Colon (CEA) _____ Ovary (CA-125) _____ Testis (AFP/hCG) _____ / _____ / _____

23: Staging procedures: (attach copies of reports)

CXR ____ Date: _____ MRI ____ Date: _____ EGD ____ Date: _____
Positive Negative Unknown Positive Negative Unknown Positive Negative Unknown

Colonoscopy ____ Date: _____ Bone Scan ____ Date: _____ Mammogram ____ Date: _____
Positive Negative Unknown Positive Negative Unknown Positive Negative Unknown

CT Scan Chest ____ Date: _____ CT Abd/Pelvis ____ Date: _____ Radiograph (Other): ____ Date: _____
Positive Negative Unknown Positive Negative Unknown positive Negative Unknown

24. Distant metastasis ____ ____ ____ *Use these codes for distant metastasis*
0 - none, 1 - peritoneum, 2 - lung, 3 - Pleura, 4 - liver, 5 - bone, 6 - central nervous system, 7 - skin, 8 - lymph nodes (distant)
9 - Other, generalized, carcinomatosis, disseminated, not specified, unknown

25. Has the patient had any of the following treatments? Where performed? _____

Chemotherapy: Yes/No Start Date: _____ Agent(s): _____

Hormone Treatment: Yes/No Start Date: _____ Type: _____

Radiation Therapy: Yes/No Start Date: _____ Stop Date: _____

Radiation Modality (circle one): *External beam / Photons / Electrons / stereotactic / Gamma Knife / Brachytherapy / Combination / Unknown*

Radiation Dose (cGY): _____ Radiation Boost Dose (cGY): _____

Other Treatment (please specify): _____

26. Physician Responsible for Ongoing Therapy/Care: _____ 27. Date last contact: _____

28. Patient Status (circle one): *Alive, free of cancer Alive, evidence of cancer Alive, cancer status unknown*
Deceased, free of cancer Deceased, evidence of cancer Deceased, cancer status unknown