

MAINE CANCER REGISTRY
Physician Report Form, 06/2005

Please submit form to: DAWN NICOLAIDES, CTR
 MAINE CANCER REGISTRY
 286 WATER STREET, 4TH FLOOR
 11 STATE HOUSE STATION
 AUGUSTA, ME 04333-0011
 PHONE: 207-287-4742

PHYSICIAN NAME
PHYSICIAN LICENSE #
PHYSICIAN ADDRESS

PATIENT INFORMATION

LAST name	FIRST NAME	MIDDLE NAME	MAIDEN NAME
NAME SUFFIX (SR. JR, III ETC)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	Sex <input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female <input type="checkbox"/> 3 Other <input type="checkbox"/> 4 Transexual <input type="checkbox"/> 9 Unknown
Race <input type="checkbox"/> 1 White <input type="checkbox"/> 2 Black <input type="checkbox"/> 3 Native American <input type="checkbox"/> 96 Asian <input type="checkbox"/> 9 Unknown <input type="checkbox"/> Other _____	Hispanic <input type="checkbox"/> 1 Yes ; If yes, ethnicity _____ <input type="checkbox"/> 2 No <input type="checkbox"/> 9 Unknown	Usual Occupation – text _____ Usual Industry – text _____	
Address at diagnosis			
Street	City	State	Zip
Current address, if different from above			
Street	City	State	Zip

CANCER INFORMATION

Date of Diagnosis (mm-dd-yyyy)	Primary Site (text description)	Histology or Morphology (text)	
Date first seen for this cancer (mm-dd-yyyy)			
Laterality (check one) <input type="checkbox"/> 0 N/A <input type="checkbox"/> 1 Right <input type="checkbox"/> 2 Left <input type="checkbox"/> 3 One side, unknown which <input type="checkbox"/> 4 Bilateral <input type="checkbox"/> 9 Paired organ, no information re laterality	Grade Code <input type="checkbox"/> 1 Well differentiated <input type="checkbox"/> 5 T-Cell <input type="checkbox"/> 2 Moderately well differentiated <input type="checkbox"/> 6 B-Cell <input type="checkbox"/> 3 Poorly differentiated <input type="checkbox"/> 7 Null Cell <input type="checkbox"/> 4 Undifferentiated, Anaplastic <input type="checkbox"/> 9 Unknown or N/A	Behavior Code <input type="checkbox"/> 0 = Benign <input type="checkbox"/> 1 = Uncertain <input type="checkbox"/> 2 = In - situ <input type="checkbox"/> 3 = Malignant	What number cancer is this (1 st , 2 nd , 3 rd , etc)?
Stage Description (complete all applicable fields) Tumor Size _____ Tumor Extension/Invasion _____ # Regional Lymph Nodes (LN) Examined _____ # Regional LN Positive _____ Identify Regional LN Involved _____ Site(s) of Distant Metastasis _____		General Summary Stage <input type="checkbox"/> In Situ <input type="checkbox"/> Localized <input type="checkbox"/> Regional by Direct Extension <input type="checkbox"/> Regional Lymph Nodes <input type="checkbox"/> Distant	Pathologic TNM, AJCC Stage T _____ N _____ M _____ Group _____ Clinical TNM, AJCC Stage T _____ N _____ M _____ Group _____

DIAGNOSTIC INFORMATION

HISTOLOGY (TISSUE SAMPLE) <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE
TEXT DESCRIPTION	
CYTOLOGY (FNA, SPUN CELLS) <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE
TEXT DESCRIPTION	
RADIOLOGY, SCANS, ULTRA SOUND <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE
TEXT DESCRIPTION	
VISUALIZATION (E.G. ENDOSCOPY) <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE
TEXT DESCRIPTION	
CLINICAL (INC. PHYS. EXAM) <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE
TEXT DESCRIPTION	

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PHYSICIAN NAME

PATIENT INFORMATION, CONTINUED

LAST name	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER
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FIRST COURSE OF TREATMENT INFORMATION COMPLETE ONLY THE FOLLOWING WHICH APPLY TO THIS PATIENT

CANCER DIRECTED SURGERY	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF CANCER DIRECTED SURGERY
SURGICAL PROCEDURE TEXT		

RADIATION THERAPY	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF RADIATION THERAPY
RADIATION THERAPY TEXT		

CHEMOTHERAPY	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF CHEMOTHERAPY
CHEMOTHERAPY TEXT		

HORMONE THERAPY	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF HORMONE THERAPY
HORMONE THERAPY TEXT		

BIOLOGICAL RESPONSE MODIFIER	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF BRM
BRM TEXT		

OTHER TREATMENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF OTHER TREATMENT
OTHER TREATMENT TEXT		

FOLLOW UP INFORMATION

VITAL STATUS <input type="checkbox"/> 1 Alive <input type="checkbox"/> 0 Dead	DATE OF DEATH OR LAST FOLLOW-UP	TUMOR STATUS <input type="checkbox"/> 1 No evidence of this Cancer <input type="checkbox"/> 2 Evidence of this Cancer <input type="checkbox"/> 9 Unknown
ICD-9-CM CODE FOR CANCER RELATED CAUSE OF DEATH:	IF DECEASED, WAS THERE AN AUTOPSY? <input type="checkbox"/> 1 YES <input type="checkbox"/> 2 NO <input type="checkbox"/> UNKNOWN	
FOLLOWING PHYSICIAN'S NAME	MANAGING PHYSICIAN'S NAME	SURGEON'S NAME
REFERRING PHYSICIAN'S NAME	INSTITUTION REFERRED FROM	INSTITUTION REFERRED TO
COMMENTS:		