

# MONTANA CENTRAL TUMOR REGISTRY ABSTRACTING FORM

Form TR-003  
Revised 8/10

|   |  |                       |   |  |  |   |  |
|---|--|-----------------------|---|--|--|---|--|
| Reporting Hospital  |  | Abstracted By         |   | Date Abstracted  |  | Date Received by MCTR   |  |
| <b>PATIENT INFORMATION</b>  |  |                       |   |  |  |   |  |
| Facility #  |  | Accession #           |   | Sequence #   |  | Date First Contact  |  |
|   |  |                       |   |  |  | Medical Record Number   |  |
| Name of Patient Last  |  | First                 |   | Middle   |  | Maiden  |  |
|   |  |                       |   |  |  | Alias   |  |
|   |  |                       |   |  |  | Primary Payer   |  |
| Physical Address No & Street  |  | City                  |   | County   |  | State   |  |
|   |  |                       |   |  |  | Zip Code  |  |
| Social Security Number  |  | Date of Birth         |   | Facility Referred From   |  | Facility Referred To  |  |
|   |  |                       |   |  |  |   |  |
| Race  |  | Hispanic Origin       |   | Sex  |  | Age   |  |
|   |  |                       |   |  |  |   |  |
| Marital Status  |  | Name of Spouse/Parent |   | Place of Birth   |  |   |  |
|   |  |                       |   |  |  |   |  |
| Telephone Number  |  |                       |   | Tobacco History  |  | Alcohol History   |  |
|   |  |                       |   |  |  |   |  |
| Usual Occupation  |  |                       |   | Usual Industry   |  |   |  |
|   |  |                       |   |  |  |   |  |
| Follow-Up Contact - Name (not spouse)   |  | Relationship          |   | No & Street  |  | City  |  |
|   |  |                       |   |  |  | State   |  |
|   |  |                       |   |  |  | Zip Code  |  |
|   |  |                       |   |  |  | Telephone Number  |  |
|   |  |                       |   |  |  |   |  |
| <b>CANCER INFORMATION</b>   |  |                       |   |  |  |   |  |
| Date of Diagnosis   |  | Primary Site          |   | Laterality   |  | Other Primary Tumors  |  |
|   |  |                       |   |  |  |   |  |
| Place of Diagnosis (if diagnosed elsewhere, please describe place)  |  |                       |   | Diagnostic Confirmation  |  |   |  |
| <input type="checkbox"/> This Hospital <input type="checkbox"/> Other Hospital<br><input type="checkbox"/> Physician's Office <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____   |  |                       |   | <input type="checkbox"/> Histology <input type="checkbox"/> Cytology <input type="checkbox"/> Microscopic <input type="checkbox"/> Lab Test<br><input type="checkbox"/> Visual <input type="checkbox"/> X-ray <input type="checkbox"/> Clinical <input type="checkbox"/> Unknown   |  |   |  |
| <p><b>Diagnostic Summary</b> (document details of physical evaluation, pathology, scopes, x-rays/scans, and lab tests including date and name of procedure(s), slide #, facility, specimen, histology, grade, behavior, tumor size, extension, surgical margins, LN's involved and examined). <b>Attach copies of surgical or pathology reports and discharge summaries, if necessary.</b></p>                  |  |                       |   |  |  |   |  |
| <b>Collaborative Staging</b><br>Tumor Size _____ Describe Size _____<br>Extension _____<br>Regional Lymph Nodes <i>Positive</i> _____    Regional Lymph Nodes <i>Examined</i> _____<br>Sites of Distant Metastases _____<br>Substantiate Stage _____  |  |                       |   | <b>SEER Summary Staging</b><br><input type="checkbox"/> In-situ <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Distant <input type="checkbox"/> Unknown<br><br><b>AJCC Staging</b><br><input type="checkbox"/> Clinical <input type="checkbox"/> Pathological<br>T _____ N _____ M _____    Stage Group _____ |  |   |  |
| <b>TREATMENT INFORMATION</b>  |  |                       |   |  |  |   |  |
| <p><b>Cumulative Treatment Summary</b> (document details of biopsy, surgery, radiation, or systemic therapy including dates, places, and types; if no therapy is given, record reason)</p>  |  |                       |   |  |  |   |  |
| <b>OUTCOMES</b>   |  |                       |   |  |  |   |  |
| <b>Status</b><br>Date of Last Contact or Death _____<br>Vital Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead<br>Cancer Status <input type="checkbox"/> No Evidence <input type="checkbox"/> Evidence <input type="checkbox"/> Unknown<br>Cause of Death _____<br>Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br>Place of Death _____ |  |                       | <b>Recurrence</b><br>Recurrence Date _____<br>Recurrence Type<br><input type="checkbox"/> In-situ <input type="checkbox"/> Local <input type="checkbox"/> Regional<br><input type="checkbox"/> Distant <input type="checkbox"/> Unknown<br>Describe _____ |  |  | <b>Comorbidities and Complications (ICD-9-CM)</b><br>1. _____<br>2. _____<br>3. _____<br>4. _____<br>5. _____<br>6. _____ |  |
| Physician – Surgeon   |  | Physician – Follow-Up |   | Physician - Managing   |  | Physician – 3   |  |
|   |  |                       |   |  |  | Physician – 4   |  |

**Fax to Montana Central Tumor Registry, (406) 444-6557.**  
**This form can be found on [www.chronicdiseaseprevention.mt.gov](http://www.chronicdiseaseprevention.mt.gov).**