

MONTANA CENTRAL TUMOR REGISTRY ABSTRACTING FORM

Form TR-003
Revised 8/10

Reporting Hospital Montana Community		Abstracted By Mary Abstractor		Date Abstracted 5/8/08	Date Received by MCTR	
PATIENT INFORMATION						
Facility # 484	Accession # 2007-00049	Sequence # 02	Date First Contact 4/6/07	Medical Record Number M-303490		
Name of Patient Last Anderson	First Margaret	Middle Meredith	Maiden Miller	Alias Marnie	Primary Payer M-care/BC	
Physical Address No & Street 1111 West Center Lane		City Somewhere	County Beaverhead	State MT	Zip Code 59888	
Social Security Number 555-55-5555		Date of Birth 10/15/1923	Facility Referred From None		Facility Referred To City Radiation Center	
Race White	Hispanic Origin Non-Hispanic	Sex Female	Age 84	Marital Status Married	Name of Spouse/Parent George	Place of Birth WA
Telephone Number (406) 555-5555		Tobacco History Never smoked		Alcohol History 1 drink/week		
Usual Occupation Accountant			Usual Industry Higgins Accounting Firm			
Follow-Up Contact - Name (not spouse) Curt Anderson		Relationship Son	No & Street 303 Nevada St	City Sometown	State AZ	Zip Code 85888
Telephone Number (999) 666-6666						
CANCER INFORMATION						
Date of Diagnosis 4/6/07	Primary Site Breast, UOQ	Laterality Right		Other Primary Tumors 01-Cervix dx'd 1962 (not reported)		
Place of Diagnosis (if diagnosed elsewhere, please describe place) <input checked="" type="checkbox"/> This Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Physician's Office <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				Diagnostic Confirmation <input checked="" type="checkbox"/> Histology <input type="checkbox"/> Cytology <input type="checkbox"/> Microscopic <input type="checkbox"/> Lab Test <input type="checkbox"/> Visual <input type="checkbox"/> X-ray <input type="checkbox"/> Clinical <input type="checkbox"/> Unknown		
<p>Diagnostic Summary (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). Attach copies of surgical or pathology reports and discharge summaries, if necessary.</p> <p>4/4/07 Dr. Miller, routine appt with breast exam; palpable lump detected. Pt has hx of lumpy breasts.</p> <p>4/6/07 Mammogram at MCH: approx 1 cm mass in ROUQ suspicious for malignancy.</p> <p>4/7/07 MCH, biopsy Rt UOQ Breast, So7-6339: Ductal adenoca, grade 2/3.</p> <p>4/14/07 Lumpectomy at MCH, So7-7846: Invasive ductal carcinoma; grade 2/3; 1.2 x 1.0 cm tumor size; cancer involves 0 of 20 axillary lymph nodes; final margins negative.</p> <p>4/14/07 ER/PR 1+ (positive); HER2/NEU not detected.</p>						
Collaborative Staging Tumor Size 1.2 cm Describe Size 1.0 x 1.2 cm per path report Extension Confined to Breast, 0/20 positive lymph nodes Regional Lymph Nodes Positive 00 Regional Lymph Nodes Examined 20 Sites of Distant Metastases None Substantiate Stage neg LN's - physician states T1c, No, Stage I				SEER Summary Staging <input type="checkbox"/> In-situ <input checked="" type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Distant <input type="checkbox"/> Unknown AJCC Staging <input type="checkbox"/> Clinical <input checked="" type="checkbox"/> Pathological T 1C N 0 M 0 Stage Group I		
TREATMENT INFORMATION						
Cumulative Treatment Summary (document details of biopsy, surgery, radiation, or systemic therapy including dates, places, and types; if no therapy is given, record reason) 4/7/07 Biopsy at MCH. 4/14/07 Lumpectomy with axillary lymph node dissection at MCH. 5/1/07 Beam radiation started at Montana Cancer Center, completed 6/15/07. Notes document 5500 cGy given for 25 days.						
OUTCOMES						
Status Date of Last Contact or Death 4/13/08 Vital Status <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Dead Cancer Status <input checked="" type="checkbox"/> No Evidence <input type="checkbox"/> Evidence <input type="checkbox"/> Unknown Cause of Death _____ Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Place of Death _____		Recurrence Recurrence Date _____ Recurrence Type <input type="checkbox"/> In-situ <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Distant <input type="checkbox"/> Unknown Describe _____		Comorbidities and Complications (ICD-9-CM) 1. 496 COPD 2. 25000 DMII 3. 4019 HTN 4. _____ 5. _____ 6. _____		
Physician - Surgeon Dr. Mark Surgeon		Physician - Follow-Up Dr. Fred Miller		Physician - Managing	Physician - 3	Physician - 4