

PHYSICIAN CANCER REPORTING FORM

Form TR-003
Revised 05/15

Reporting Physician and Address	Physician Phone	Date Form Completed	Date Received by MCTR
	Physician License or NPI #	Form Completed By	

PATIENT INFORMATION

Name of Patient	Last	First	Middle	Maiden	Alias	Name of Spouse/Parent
Social Security Number	Date of Birth	Age	Referred From	Referred To		
Race	Hispanic Ethnicity		Sex	Marital Status		
<input type="checkbox"/> White <input type="checkbox"/> Am. Ind <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Unk <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Div <input type="checkbox"/> Widow <input type="checkbox"/> Sep <input type="checkbox"/> Unk		
Physical Address	No & Street	City	County	State	Zip Code	Place of Birth
Telephone Number	Family History of Cancer	Tobacco History			Alcohol History	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Never <input type="checkbox"/> Cigarette <input type="checkbox"/> Pipe <input type="checkbox"/> Chew <input type="checkbox"/> Previous Use <input type="checkbox"/> Unk			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previous <input type="checkbox"/> Unk	
Primary Payer	Usual Occupation		Usual Industry			

CANCER INFORMATION

Date of Initial Diagnosis	Primary Site	Laterality	Other Primary Tumors
		<input type="checkbox"/> Not Applicable <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Unk	
<u>Physical Findings (x-ray, scans, scopes)</u>			<u>SEER Summary Staging</u> <input type="checkbox"/> In-situ <input type="checkbox"/> Local <input type="checkbox"/> Regional DE* <input type="checkbox"/> Regional LN* <input type="checkbox"/> Distant* <input type="checkbox"/> Unknown * Describe: _____
<u>Pathology (Histology and Grade) (attach copies of reports)</u>			
<u>Size of Tumor</u>			
<u>Lymph Node Involvement</u>			
<u>For Melanoma</u>			
Depth of Invasion (Breslow's): _____		Ulceration: <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>For Prostate</u>
Clarks Level: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV			PSA Level prior to bx: _____
			<u>For Breast</u>
			ERA/PRA Status: _____
			HER2 Status: _____

TREATMENT INFORMATION

<u>Surgery</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Radiation</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Systemic Therapy</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type		Type and cGy		Agents	
_____		_____		_____	
_____		_____		_____	
Date		Date Started and Ended		Date Started	
_____		_____		_____	

OUTCOMES

<u>Status</u>	<u>Physicians</u>
Date of Last Contact or Death _____	Surgeon _____
Vital Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead Cancer Status <input type="checkbox"/> No Evidence <input type="checkbox"/> Evidence <input type="checkbox"/> Unknown	Following _____
Cause of Death _____ Place of Death _____	Other _____

Please submit supporting text/documentation (e.g., pathology reports, radiology findings, pre-operative H&P, etc), to verify diagnosis, staging, histology, treatment, etc.
 Please mail this form and documentation to the Montana Central Tumor Registry, PO Box 202952, 1400 Broadway, Room C-317, Helena, MT 59620.
 Or fax the reports to (406) 444-6557. For questions, contact the MCTR at (406) 444-6786. This document is also on www.chronicdiseaseprevention.mt.gov.