

HOSPITAL CANCER ABSTRACTING FORM

Form TR-003
Revised 06/21

Reporting Hospital		Abstracted By		Date Abstracted		Date Received by MCTR		
PATIENT INFORMATION								
Facility #	Accession #	Sequence #	Date of First Contact		Medical Record Number	Primary Payer		
Name of Patient Last First Middle Maiden Alias						Name of Spouse/Parent		
Physical Address No & Street City County State Zip Code						Place of Birth		
Social Security Number		Date of Birth	Age	Facility Referred From		Facility Referred To		
Race <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			Hispanic Ethnicity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Div <input type="checkbox"/> Widow <input type="checkbox"/> Sep <input type="checkbox"/> Unk	
Telephone Number	Tobacco History <input type="checkbox"/> Never <input type="checkbox"/> Cigarette <input type="checkbox"/> Pipe <input type="checkbox"/> Chew <input type="checkbox"/> e-Cig, Vape, Liquid <input type="checkbox"/> Previous Use <input type="checkbox"/> Unk				Alcohol History <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previous <input type="checkbox"/> Unk			
Usual Occupation				Usual Industry				
Follow-Up Contact - Name (not spouse) Relationship No & Street City State Zip Code Telephone Number								
CANCER INFORMATION								
Date of Diagnosis		Primary Site		Laterality <input type="checkbox"/> Not Paired <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Unk		Other Primary Tumors		
Place of Diagnosis (if diagnosed elsewhere, please describe place) <input type="checkbox"/> This Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Physician's Office <input type="checkbox"/> Describe _____				Diagnostic Confirmation <input 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				
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.								
<u>Staging</u> Tumor Size in mm _____ Describe Size _____ Extension/Spread _____ Regional Lymph Nodes <i>Positive</i> _____ Regional Lymph Nodes <i>Examined</i> _____ Sites of Distant Metastases _____ Describe Stage _____				<u>SEER Summary Staging</u> <input type="checkbox"/> In-situ <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Distant <input type="checkbox"/> Unknown <u>AJCC Staging</u> <input type="checkbox"/> Clinical <input type="checkbox"/> Pathological T _____ N _____ M _____ Stage Group _____				
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)								
OUTCOMES								
<u>Status</u> Date of Last Contact or Death _____ Vital Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead Cancer Status <input type="checkbox"/> No Evidence <input type="checkbox"/> Evidence <input type="checkbox"/> Unk Status Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk if Autopsy Place of Death _____		<u>Recurrence</u> 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 _____			<u>Comorbidities and Complications (ICD-10-CM)</u> 1. _____ 2. _____ 3. _____ 4. _____			
Physicians (include surgeon, following physician, managing physician, etc)								
Fax to Montana Central Tumor Registry, (406) 444-6557; for questions contact the MCTR at (406) 444-6786 This form can be found on https://dphhs.mt.gov/publichealth/Cancer/TumorRegistry								