DERMATOLOGY CANCER REPORTING FORM

Form TR-003
Revised 05/2021

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
☐ White ☐ Am. Ind ☐ Black ☐ Asian ☐ Unk ☐ Other

Hispanic Ethnicity
☐ Yes ☐ No ☐ Unk

Sex
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Div ☐ Widow ☐ Sep ☐ Unk

Physical Address No & Street City County State Zip | Place of Birth

Telephone Number

Tobacco History
☐ Never ☐ Cigarette ☐ Pipe ☐ Chew ☐ e-Cig, Vape, Liquid ☐ Previous Use ☐ Unk

Alcohol History
☐ Yes ☐ No ☐ Previous ☐ Unk

Primary Payer | Usual Occupation | Usual Industry

CANCER INFORMATION

Date of Initial Diagnosis | Primary Site

Laterality
☐ Not Paired ☐ Right ☐ Left ☐ Unk

Other Primary Tumors

Physical Findings (physical evaluation, x-ray, scans, scopes)

Pathology (Histology and Grade) (attach copies of all related pathology reports)

Size of Tumor

Lymph Node Involvement (include number of lymph nodes excised and number positive)

For Melanoma

Depth of Invasion (Breslow's) in mm: _____ Ulceration: ☐ Yes ☐ No VGP: ☐ Yes ☐ No

Clarks Level: ☐ I ☐ II ☐ III ☐ IV Mitotic Rate: _____ Regression: ☐ Yes ☐ No

Summary Staging
☐ In-situ ☐ Local ☐ Regional DE*
☐ Regional LN* ☐ Distant* ☐ Unknown
* Describe: _____

AJCC Staging

Clinical

T _____ N _____ M _____ Stage _____

Pathological

T _____ N _____ M _____ Stage _____

TREATMENT INFORMATION

Surgery (check all that apply and provide date)

☐ Shave Biopsy: Date _____
☐ Punch Biopsy: Date _____
☐ Excision/Excisional Biopsy: Date _____
☐ MOHS: Date _____
☐ Wide Excision: Date _____
☐ Re-Excision: Date _____
☐ Wide Re-Excision: Date _____

Other Therapy
Describe any other non-surgical treatment given

_____

Date Started

_____

OUTCOMES

Status

Date of Last Contact or Death _____

Vital Status ☐ Alive ☐ Dead

Cancer Status ☐ No Evidence ☐ Evidence ☐ Unknown

Physicians

Surgeon _____

Following _____

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.