For data completeness, we ask that *ALL* fields be completed when information is available

Print Form

Missouri Cancer Registry
Cancer Reporting Form
PO Box 718
Columbia MO 65205
Fax: (573) 884 9655
Toll free: (866) 240 8809

Website: http://mcr.umh.edu

Entered by: _____

Date: _____

For MCR Use Only

☐ Web Plus
☐ Suspense
☐ CRS+
☐ Abstract Plus

FACILITY INFORMATION

Facility Name:	Physician Name:	NPI#:

PATIENT INFORMATION

Patient Last Name:	Middle Initial:	First Name:	
Street Address: (PLEASE BE SURE TO INCLUDE ADDRESS)	City:	State: Missouri	Zipcode:
SSN: _____ **Vital Status:** ☐ Alive ☐ Dead	DOB: _____ **(MM/DD/YYYY)**	Primary Payer at Diagnosis: ☐ Not insured ☐ Self pay ☐ Insured, nos ☐ Medicaid/Medicare ☐ Military ☐ Unknown	

PATIENT DEMOGRAPHICS

Race:
☐ White
☐ African American
☐ Native American
☐ Asian/Pacific Islander
☐ Other

Hispanic/Spanish Ethnicity:
☐ Yes ☐ No
☐ Unknown

Sex: ☐ Male ☐ Female
☐ Other

Alcohol History: ☐ Yes ☐ No ☐ Unk

Tobacco History: ☐ Yes ☐ No ☐ Unk

Marital Status at Diagnosis:
☐ Married ☐ Single ☐ Widowed
☐ Separated ☐ Unknown

_____
Usual or longest held occupation

_____
Industry or company of usual or longest held/known occupation

CANCER #1

Is this:
☐ A cancer not previously diagnosed
☐ A recurrence of a previously diagnosed cancer
☐ A history of cancer with no evidence of that cancer
☐ A history of cancer with evidence of that cancer

Date of Diagnosis: _____

Site of Diagnosis: _____

Laterality: ☐ Right ☐ Left ☐ Unknown

Histology: _____

Treatment: _____ **Date:** _____

Treatment _____ **Date:** _____

Stage of Disease: _____

CANCER #2

Is this:
☐ A cancer not previously diagnosed
☐ A recurrence of a previously diagnosed cancer
☐ A history of cancer with no evidence of that cancer
☐ A history of cancer with evidence of that cancer

Date of Diagnosis: _____

Site of Diagnosis: _____

Laterality: ☐ Right ☐ Left ☐ Unknown

Histology: _____

Treatment _____ **Date:** _____

Treatment: _____ **Date:** _____

Stage of Disease: _____

OTHER RELEVANT INFORMATION

Other physicians/facilities directly involved in patient's cancer care:

Other relevant patient information:

FOLLOW BACK INFORMATION

Person completing form:	Date:	Contact information (EMAIL, PHONE AND FAX):

Created/Updated 11/2008

Please FAX or MAIL completed forms to the number/address listed at the top of the form

Reset Form