

Instructions for Missouri Cancer Registry Cancer Reporting Form

Physician/Facility Information

-Practice Name: Record full name of the facility/practice reporting the cancer information including Physician name.

Patient Information

- Full last name, middle initial and first name. Note any aliases or nicknames.
- Residence address at time of diagnosis.
- Social security number: Do *not* use a spouse's social security number.
- Primary payer at diagnosis: Check insurance type

Patient Demographics

- Check the box that best describes the patient's race. Hispanic/Spanish ethnicity: Check if patient is of Hispanic/Spanish origin. See manual for additional instructions.
- Indicate patient's history of tobacco and alcohol use.
- Record the patient's marital status.
- Vital status: Check one

*****Please provide *dates* where indicated. If actual date is unknown please provide an estimated date based on your admission records. *** This might be clinical, radiological or based on a Pathological report.**

Cancer Identification/Staging/Treatment

- New or Recurrence: If this is the first time the patient has been diagnosed with this cancer, choose New. If this is a recurrence of previously diagnosed cancer, choose Recurrence.
- Procedures Performed: Document the type of procedure that was performed to diagnose the patient's cancer. Record the date of the procedure.
- Surgical Procedure Type: Document the surgical procedure that was performed. Record the date of the surgical procedure.
- Primary Cancer site: Record the cancer based on location of cancer (i.e. breast, colon, etc.).
- Date of Diagnosis: Record the Date of Diagnosis.
- Laterality: If the cancer occurred in a paired organ, indicate whether right, left or bilateral.
- Ulceration: Ulceration is the breakdown of the skin over the melanoma. Record any information given regarding ulceration located in the path report.
- Breslow's information: For melanoma cases, record thickness of the tumor in millimeters.
<https://www.oncolink.org/cancers/skin/melanoma/treatments/understanding-your-pathology-report-melanoma>
- Record the tumor size: Record tumor size in millimeters.
- Histology (cell type): This information may be found on the pathology report. Histology describes the type of cancer cell (adenocarcinoma, squamous, etc.)
- Grade: Choose one. This can be found on the path report.
- Lymph node involvement: Record # positive / # removed: Ex: 4/10
- Pre Op Tumor Markers: Add value if known.
- SEER Staging of Disease: <https://training.seer.cancer.gov/ss2k/staging/howto/simple.html>
- TNM: <https://www.cancer.org/cancer/melanoma-skin-cancer/detection-diagnosis-staging/melanoma-skin-cancer-stages.html>
- Staging procedures: Attach copies of reports, if available.
- Distant metastasis: If cancer has spread to other sites beyond the primary site, record the site to which it has spread.
- Chemotherapy: List agents and dates for any known chemotherapy given.
- Hormone Treatment: List start date and type of hormone treatment given.
- Radiation Treatment: List start date for any radiation treatment given.
- Radiation Modality: Choose type of radiation given. If not listed, choose Other and specify.
- Other Treatment: Document the type of treatment the patient received. Include the procedure name and the place the procedure was performed.
- Other relevant information (previous history of other cancer(s)/condition(s): Document any other relevant information regarding previous history of other cancer(s) and/or conditions(s) if known. This can include primary care physicians and specialty physicians such as urologist, dermatologist, etc.
- Date last contact: Record the last time the patient was seen by your facility.