

**Missouri Cancer Registry  
Facility Directory Update Form**

PO Box 718  
Columbia MO 65205  
Fax: (573) 884 9655  
Toll free: (800) 392 2829  
Website: <http://mcr.umh.edu>

Entered by: _____	<input type="checkbox"/> Web Plus
Date: _____	<input type="checkbox"/> Tracking
	<input type="checkbox"/> Suspense
	<input type="checkbox"/> CRS Plus
	<input type="checkbox"/> Abstract Plus

**For MCR Use Only**

Date updated: \_\_\_\_\_

Please print or type all information below

**ADMINISTRATIVE FACILITY INFORMATION**

Facility Name:		Address (Street or PO Box):	
City, State, Zip code:			
Facility Number (FIN):	NPI Number:	Main Phone:	
Administrator (with title & credentials):			
Supervisor (with title & credentials):	Department:	Phone:	
Main contact (please include title):	Department:	Phone:	
Email:		Fax:	
Alternate contact (please include title and department):	Phone:	Alternate contact email:	

<b>FACILITY-SPECIFIC INFORMATION</b>	<b>FOR PATH LABS ONLY</b>
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<p><b>Bed size:</b> _____</p> <p><b>Reporting Mechanism:</b></p> <p><input type="checkbox"/> Computerized (indicate software) _____</p> <p><input type="checkbox"/> Low-volume (less than 75 cases annually)</p> <p><b>Reporting Status:</b></p> <p><input type="checkbox"/> Incidence</p> <p><input type="checkbox"/> Survival</p> <p><b>ACoS Accredited:</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Registry Reference Year:</b> _____</p> <p><b>Estimated number of cancer cases reported annually:</b> _____</p>	<p><b>Data submitted:</b></p> <p><input type="checkbox"/> Registry abstract</p> <p><input type="checkbox"/> Copies from medical record</p> <p><b>Data Transmission Method:</b></p> <p><input type="checkbox"/> Fax <input type="checkbox"/> FTP</p> <p><input type="checkbox"/> Web Plus upload</p> <p><input type="checkbox"/> Other _____</p> <p><b>Do you report cases for another facility?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Name(s) of facilities*:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><small>*Please fill out a separate form for each facility.</small></p>	<p><b>How does your Information System retrieve diagnostic information?</b></p> <p><input type="checkbox"/> ICD-10 <input type="checkbox"/> SNOMED</p> <p><input type="checkbox"/> CPT <input type="checkbox"/> Free Text</p> <p><input type="checkbox"/> Other _____</p> <p><b>What software program/vendor do you use?</b></p> <p>_____</p> <p><b>What format is available for exported data:</b></p> <p><input type="checkbox"/> .txt file <input type="checkbox"/> .xls file</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Please indicate here if your facility does not process anatomic, cytology, bone marrow or autopsy specimen types.</p>
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