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

Missouri Cancer Registry
LTCF 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
☐ Tracking
☐ Suspense
☐ Précis
☐ Abstract Plus

Facility Information

Facility Name:

☐ RCFI ☐ RCFII ☐ ICF ☐ SNF ☐ ALF

Patient Information

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

Patient Demographics

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

Hispanic/Spanish Ethnicity:
☐ Yes ☐ No ☐ Unknown

Sex: ☐ Male ☐ Female ☐ Other

Tobacco History: ☐ Yes ☐ No ☐ Unk

Alcohol History: ☐ Yes ☐ No ☐ Unk

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

Usual or longest held occupation

Industry or company of usual or longest held/known occupation

Date admitted to your facility: ____________

Date of Last Contact or Death (MM/DD/YYYY)

Facility transferred to/from (facility name)

Physician name and phone number

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: ____________________

Laterality: ☐ Right ☐ Left ☐ Unknown

Histology: ____________________

Treatment: ____________ **Date:** ____________

Treatment ____________ **Date:** ____________

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: ____________________

Laterality: ☐ Right ☐ Left ☐ Unknown

Histology: ____________________

Treatment ____________ **Date:** ____________

Treatment: ____________ **Date:** ____________

Other Relevant Information/Comments

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

Follow Back Information

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

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

Created/Updated 11/2006