

**Missouri Cancer Registry
Hospital 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: _____

ADMINISTRATIVE FACILITY INFORMATION

Hospital Name:		Address (Street or PO Box):	
City, State, Zipcode:			
Hospital 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:

FACILITY-SPECIFIC INFORMATION

<p>Bed Size: _____</p> <p>Reporting Mechanism:</p> <p><input type="checkbox"/> Computerized (indicate software) _____</p> <p><input type="checkbox"/> Low-volume (less than 75 cases annually)</p> <p>Reporting Status:</p> <p><input type="checkbox"/> Incidence</p> <p><input type="checkbox"/> Survival</p> <p>Estimated number of cancer cases reported annually: _____</p>	<p>Data Transmission Method:</p> <p><input type="checkbox"/> Chart <input type="checkbox"/> FTP</p> <p><input type="checkbox"/> Web Plus</p> <p><input type="checkbox"/> Other (please specify): _____</p> <p>ACoS Accredited:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Registry Reference Year: _____</p>	<p>Do you report cases for another hospital?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of hospital(s):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><i>Please fill out a separate form for each hospital.</i></p>
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