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

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: _____

Date: _____

For MCR Use Only

- ☐ Web Plus
- ☐ Tracking
- ☐ Suspense
- ☐ CRS Plus
- ☐ Abstract Plus

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:

FACILITY-SPECIFIC INFORMATION

Bed size: _____

Reporting Mechanism:

- ☐ Computerized (indicate software) _____
- ☐ Low-volume (less than 75 cases annually)

Reporting Status:

- ☐ Incidence
- ☐ Survival

ACoS Accredited:

- ☐ Yes ☐ No

Registry Reference Year: _____

Estimated number of cancer cases reported annually: _____

Data submitted:

- ☐ Registry abstract
- ☐ Copies from medical record

Data Transmission Method:

- ☐ Fax ☐ FTP
- ☐ Web Plus upload
- ☐ Other _____

Do you report cases for another facility?

- ☐ Yes ☐ No

Name(s)of facilities*:

_____

_____

_____

**Please fill out a separate form for each facility.*

FOR PATH LABS ONLY

How does your Information System retrieve diagnostic information?

- ☐ ICD-10 ☐ SNOMED
- ☐ CPT ☐ Free Text
- ☐ Other _____

What software program/vendor do you use?

_____

What format is available for exported data:

- ☐ .txt file ☐ .xls file
- ☐ Other _____

☐ **Please indicate here if your facility does not process anatomic, cytology, bone marrow or autopsy specimen types.**

Created/Updated 5/16

Please FAX completed forms to the number listed at the top of the form