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) 882 4042
Toll free: (866) 240 8809
Website: http://mcr.umh.edu

Entered by: _____

Date: _____

For MCR Use Only

☐ Web Plus
☐ Suspense
☐ CRS+
☐ Abstract Plus

FACILITY INFORMATION

Facility Name:	Facility Address:
City, State and Zip code:	Facility Phone Number:

PATIENT INFORMATION

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

PATIENT DEMOGRAPHICS

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

Hispanic/Spanish Ethnicity:
☐ Yes ☐ No ☐ Unknown

Sex: ☐ Male ☐ Female ☐ Other

Alcohol History: ☐ Yes ☐ No ☐ Unk

Tobacco History: ☐ Yes ☐ No ☐ Unk

Marital Status at Diagnosis:
☐ Married ☐ Single ☐ Widowed
☐ Divorced ☐ Unknown

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 of Diagnosis: _____

Laterality: ☐ Right ☐ Left ☐ Unknown

Histology: _____

Treatment: _____ **Date:** _____

Treatment _____ **Date:** _____

Stage of Disease:
☐ In situ ☐ Local ☐ Regional
☐ Distant ☐ Unknown

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 of Diagnosis: _____

Laterality: ☐ Right ☐ Left ☐ Unknown

Histology: _____

Treatment _____ **Date:** _____

Treatment: _____ **Date:** _____

Stage of Disease:
☐ In situ ☐ Local ☐ Regional
☐ Distant ☐ Unknown

OTHER RELEVANT INFORMATION

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

Other relevant patient information:

FOLLOW BACK INFORMATION

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

Updated 09/2012

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