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

Missouri Cancer Registry Melanoma 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

Physician Information

Physician Name:	State License #:	NPI # :

Patient Information

Patient Last Name:	Middle Initial:	First Name:	
Street Address: (please be sure to include *address*)	City:	State:	Zipcode:
SSN:	DOB: ____________ (MM/DD/YYYY)	Primary Payer at Diagnosis: ☐ Not insured ☐ Self pay ☐ Insured, nos ☐ Medicaid/Medicare ☐ Military ☐ Unknown	

Patient Demographics

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

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
☐ Separated ☐ Unknown

Usual or longest held occupation

Industry or company of usual or longest held/known occupation

Cancer Identification

Date of Diagnosis: ____________________

Site: ____________________

Is this the Primary Site: ☐ Yes ☐ If no, primary site ____________

Histology: ____________________

Histology/path report attached: ☐ Yes ☐ No

Laterality: ☐ Right ☐ Left

Ulceration: ☐ Yes ☐ No

Tumor size: ____________________

Lymph node involvement: ☐ Yes ☐ No ☐ Unk

Clark's Level: ____________________

Breslow's information: ____________________

SEER Staging of Disease:
☐ In situ ☐ Local ☐ Regional*
☐ Distant* ☐ Unknown*

***Describe:** ____________________

History of Previous Melanoma?
- ☐ No history of previous melanoma
- ☐ Yes, but previous melanoma at another location
- ☐ Yes, this is a recurrence ☐ Unknown

Treatment

Surgery/procedure performed:
☐ Incisional biopsy ☐ Punch biopsy ☐ Wide/re-excision
☐ Excision, nos ☐ Shave biopsy

Date of Procedure: ____________________

Studies performed included:
☐ Lymphoscintigraphy ☐ Sentinel node biopsy
☐ Other: ____________________

Other performed/known treatments:

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

Status of patient: ☐ Alive ☐ Dead

Hospital/Physician Referred from

Hospital/Physician Referred to

Other relevant information (previous history of other cancer(s)/conditions):

Follow Back Information

Person completing form:	Date:	Contact information (email, phone or fax):

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

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