Nevada Central Cancer Registry
Cancer Incidence Reporting Form

Facility Information

Name	NPI#

Reporting Physician Information

Physician Managing ☐ Physician Follow-up ☐ Physician Surgeon ☐ Physician Treatment ☐

Name and Address	Phone #	NPI#	Date Received by NCCR
	Date Form Completed	Form Completed By	

Referred From	Referred To

Patient Information at Diagnosis

Last Name	First Name	Middle Name	Maiden	Alias

Social Security Number	Date of Birth	Sex	Race	Ethnicity

Physical Address	City	State	Zip	County

Place of Birth-State	Place of Birth-Country	Marital Status	Primary Payer

Usual Occupation	Usual Industry

Family History of Cancer	Tobacco History	Alcohol History
Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐

Cancer Information

Please submit supporting text/documentation (e.g. pathology reports, laboratory reports, radiology findings, pre-operative H&P, etc.), to verify diagnosis staging, histology, bio-markers, grade, treatment, etc.

Date of Initial Diagnosis	Primary Site	Laterality	Other Primary Tumors

Diagnostic Confirmation
Histology ☐ Cytology ☐ Microscopic ☐ Lab Test ☐ Visual ☐ X-ray ☐ Clinical ☐ Unknown ☐

Physical Findings (X-ray, scans, scopes)

Pathology: (attach copies of reports)
Incisional ☐ Excisional ☐ Other ☐ (Specify Histology, Behavior Code, and Grade)

For Melanoma	**For Prostate**	**For Breast**
Depth of Invasion (Breslow's): _____ Ulceration: Yes ☐ No ☐ Clark's Level: I ☐ II ☐ III ☐ IV ☐	PSA Level prior to bx: _____ Gleason Score: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	ERA/PRA Status: _____ Nottingham: Low ☐ Intermediate ☐ High ☐

Collaborative Staging
Tumor Size: _____ Extension: _____
Regional Lymph Nodes: Examined: _____ Positive: _____
Sites of Distant Metastases: _____
Substantiate Stage:

SEER Summary Stage
In-situ ☐ Local ☐ Regional ☐ Distant ☐ Unknown ☐

AJCC Staging
Clinical ☐ T____ N_____M _____Stage Group _____
Pathological ☐ T____ N_____M _____Stage Group _____

Treatment Information

Surgery (attach copies of records) Yes ☐ No ☐ Unknown ☐ Surgery or Admission Date: _____
Name of surgery(ies):

Radiation	**Hormone**	**Chemo**	**Immuno**	**Hematologic**	**Endocrine**
Start Date: _____ End Date: _____ Type: _____ Dose: _____	Start Date: _____ End Date: _____ Type: _____ Dose: _____	Start Date: _____ End Date: _____ Type: _____ Dose: _____	Start Date: _____ End Date: _____ Type: _____ Dose: _____	Start Date: _____ End Date: _____ Type: _____ Dose: _____	Start Date: _____ End Date: _____ Type: _____ Dose: _____

Other	Date	Type	Dose

Outcomes

Status	**Recurrence**	**Comorbidities and Complication (ICD-9-CM)**
Date of Last Contact or Death:_____ Vital Status: Alive ☐ Dead ☐ Cancer Status: No Evidence ☐ Evidence ☐ Unknown ☐ Cause of Death: _____ Place of Death: _____ Autopsy: Yes ☐ No ☐ Unknown ☐	Recurrence Date: _____ Recurrence Type: _____ In-situ ☐ Local ☐ Regional ☐ Distant ☐ Unknown ☐ Describe:	1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Please mail or fax this form and documentation to: Nevada Central Cancer Registry, 4126 Technology Way #200 Carson City, NV 89706. Fax: (775) 684-5999