NEVADA CENTRAL CANCER REGISTRY

4126 Technology Way, Suite 200, Carson City, NV, 89706 Phone: 775-684-5968 Fax: 775-684-5999

UROLOGY REPORTING FORM

Reporting Facility Name:		**NPI:**	
Reporting Physician Name:		**NPI:**	
Address:			
City:	**State:**	**Zip:**	**Phone:**
Ordering (Managing) Physician:			

PATIENT DEMOGRAPHIC INFORMATION

Patient's Last Name:	**First:**	**Middle:**	**Maiden:**
SSN:	**DOB:**	**Birth State:**	**Birth Country:** ☐ USA ☐ Unknown ☐ Other:
Sex: ☐ Male ☐ Female ☐ Other _____		**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	
Primary Payer: ☐ Insured ☐ Not Insured ☐ Medicaid ☐ Medicare ☐ Self-Pay ☐ VA ☐ Military ☐ Indian/Public Health Services			
Race (*Mark all that apply*)**:** ☐ White ☐ African American ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Other _____			**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic
Address Street:		**City:**	**State:** **Zip:**
Occupation:	**Industry:**	**Date of Last Contact:**	**Vital Status:** ☐ Dead ☐ Alive Evidence of Tumor: ☐ Yes ☐ No

CANCER AND STAGING INFORMATION

Date of Diagnosis:	**Tumor Site:**	**Laterality:** ☐ Right ☐ Left ☐ Both ☐ Unknown	**Tumor Size (*Millimeters*):**	**Histology (*Type of cancer*):**

Pathology/Laboratory Findings:

Values: PSA _____ Gleason's Score: _____ + _____ = _____ AFP _____ LDH _____ hCG _____

Surgical Treatment:

TURP	Prostatectomy	Orchiectomy	TURB	Cystectomy	Nephrectomy
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____

Other (*Please Specify*): _____ Date: _____

X-Ray/Scans Findings relevant to the diagnosis or treatment of this cancer (CXR, MRI, CT, PET, etc.):

TNM Staging: ☐ Clinical ☐ Pathological ☐ Unknown

T _____ N _____ M _____ Stage Group _____

Please attach copies of surgical or pathology report if necessary

TREATMENT INFORMATION (*MARK ALL THAT APPLY*)

Chemotherapy: ☐ Yes ☐ No ☐ Unknown	Agents, duration:	Date Started:
Radiation: ☐ Yes ☐ No ☐ Unknown	Modality Type, Volume, and Number of Treatments:	Date Started: Date Ended:
Hormone/Other Therapy: ☐ Yes ☐ No ☐ Unknown	Type, duration:	Date Started:
Referred to Hospital or other Physician for this cancer? ☐ Yes ☐ No	Hospital Name: Physician Name:	

Please FAX or MAIL completed form and supporting documents to the number/address listed at the top of the form