NEVADA CENTRAL CANCER REGISTRY

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

# TREATMENT REPORTING FORM

| | |
|---|---|
| **Reporting Facility Name:** | **NPI:** |
| **Reporting Physician Name:** | **NPI:** |
| **Address:** | |

| | | | |
|---|---|---|---|
| **City:** | **State:** | **Zip:** | **Phone:** |

| | |
|---|---|
| **Referred <u>from</u> Hospital or other Physician for this cancer?** ☐ Yes ☐ No | Hospital Name: |
| | Physician Name: |

## 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*):** |

**TNM Staging:** ☐ Clinical ☐ Pathological ☐ Unknown

T _____ N _____ M _____ Stage Group _____

## CHEMOTHERAPY TREATMENT INFORMATION

| | | |
|---|---|---|
| **Date Chemo Started:** | **Agents:** | **Duration:** |

## RADIATION TREATMENT INFORMATION

| | |
|---|---|
| **Date Radiation Started:** | **Radiation Treatment Volume (Site):** |
| **Regional Treatment Modality:** | **Regional Dose: cGy** |
| **Boost Treatment Modality:** | **Boost Dose: cGy** |

| | | |
|---|---|---|
| **Number of Treatments:** | **Radiation/Surgery Sequence:** | **Date Radiation Ended:** |

**Reason for No Radiation:**

Form Version September 2017

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