NEVADA CENTRAL CANCER REGISTRY

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

DIAGNOSTIC/IMAGING CENTER REPORTING FORM

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

City:	**State:**	**Zip:**	**Phone:**
Ordering (Managing) Physician:			

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

Date of Diagnosis:	**Tumor Site:**	**Laterality:** ☐ Right ☐ Left ☐ Both ☐ Unknown	**Tumor Size (*Millimeters*):**	**Histology (*Type of cancer*):**
Date of Procedure/Imaging:	**Procedure/Imaging Name:**			
Findings:				
Conclusions:				
Recommendations:				

Please attach copy of radiology report if necessary

Form Version September 2017

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