NEVADA CENTRAL CANCER REGISTRY

CANCER REPORTING FORM-INSTRUCTIONS

Required Field: The facility/physician MUST collect and report the information with data collection efforts including review of the patient's chart, outpatient records or other available records, as well as making inquiries with other facilities or the physician on record as is necessary to obtain the information. **If the information is unknown for a specific data field, please refer to the unknown coding associated with that data field. Please note the form will be returned if any required fields are missing.**

Reportable Field: The facility/physician MUST report the information if it can be located within the patient's chart, outpatient records or other available records, but need not make inquiries of other facilities of physician's offices. **If the information is unknown for specific data field, please refer to the unknown coding associated with that data field.**

Reporting Facility Name: (Required Field) Enter the full name of your facility.

Facility NPI: (Required Field) Enter the facility National Provider Identification Number.

Reporting Physician Name: (Required Field) Enter the name of the physician.

Physician NPI: (Required Field) Enter the physician National Provider Identification Number.

Address, City, State, Zip, and Phone: (Required Field) Enter the facility or individual physician full address information in these fields.

PATIENT DEMOGRAPHIC INFORMATION

Patient's Last Name: (Required Field) Enter patient's last name.

First: (Required Field) Enter patient's first name.

Middle: (Reportable Field) Enter patient's middle name. Initial may be used if full middle name is not available. Leave blank if no middle name/initial is given.

Maiden: (Reportable Field) Enter the patient's Maiden Name. If the patient has no maiden name (male) or the information is not available, enter unknown.

SSN: (Required Field) Enter the patient's Social Security Number XXX-XX-XXXX. Use 999-99-9999 if the patient does not have a SSN, SSN is unknown, or patient refused to give SSN.

DOB: (Required Field) Enter the patient's date of birth YYYY/MM/DD. Please double-check date of birth for accuracy. Leave the year, month and/or day blank when they cannot be estimated or are unknown.

Birth State: (Reportable Field) Enter the patient's state of birth. If unavailable, enter unknown.

Birth Country: (Reportable Field) Check appropriate box. If Other, indicate country of birth. If not known, check unknown.

Sex: (Required Field) Check appropriate box. If other, indicate sex of the patient.

Marital Status: (Reportable Field) Check appropriate box.

Primary Payer: (Required Field) Check appropriate box.

Race: (Required Field) Check appropriate box to describe the race of the patient. If Multi-racial, check as many boxes that apply. If Other, indicate the race of the patient.

Ethnicity: (Required Field) Check appropriate box to identify if the patient is classified as Hispanic.

Address Street: (Required Field) Enter the patient's residential address at the time of diagnosis.

City, State, Zip: (Required Field) Enter the City, State (2 digit format), Zip Code (5 digit format).

Occupation: (Reportable Field) Enter the patient's usual occupation. If unavailable, enter unknown.

Industry: (Reportable Field) Enter the patient's primary type of business of employment. If unavailable, enter unknown.

Date of Last Contact: (Required Field) Enter the date of last contact with the patient or the date of death YYYY/MM/DD.

Vital Status: (Required Field) Enter the patient's vital status at the date of last contact YYYY/MM/DD.

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CANCER AND STAGING INFORMATION

Date of Diagnosis: (Required Field) Enter the date of initial diagnosis for this tumor. YYYY/MM/DD. Leave the year, month and/or day blank when they cannot be estimated or are unknown.

Tumor Site: (Required Field) This refers to the anatomic site (on the body) where the tumor being reported was found. Examples are: "Descending Colon," "Breast," and "Prostate." Do not leave blank.

Laterality: (Reportable Field) Check the appropriate box to indicate laterality. Choose the side of a paired organ, or the side of the body on which the reportable tumor was found. If not known, check unknown.

Tumor Size: (Reportable Field) Enter the largest tumor size dimension or diameter of the primary tumor in millimeters. If unavailable, enter unknown.

Histology: (Reportable Field) This refers to the histology that best describes the type of tumor found. Enter the code or description of the tumor. Examples are: "Adenocarcinoma." If unavailable, enter unknown.

Diagnostic Confirmation: (Reportable Field) Check appropriate box. If not known, check unknown.

TNM Staging: (Reportable Field) The TNM classification system was developed as a tool for physicians to stage different types of cancer based on certain, standardized criteria. This system is based on the extent of the tumor (T), the extent of spread to the lymph nodes (N), and the presence of metastasis (M). Because each cancer type has its own classification system, letters and numbers do not always mean the same thing for every kind of cancer. Once the T, N, and M are determined, they are combined, and an overall stage group of 0, I, II, III, IV is assigned. Sometimes these stages are subdivided as well, using letters such as IIIA and IIIB. Check the appropriate box and complete the TNM and Stage Group fields. If not known, check unknown.

Please attach copies of surgical or pathology report if necessary

TREATMENT INFORMATION (*MARK ALL THAT APPLY*)

Surgery: (Reportable Field) Check appropriate box. If yes, complete procedure name and date of procedure. Leave the year, month and/or day blank when they cannot be estimated or are unknown.

Chemotherapy: (Reportable Field) Check appropriate box. If yes, complete agent, duration information and date chemotherapy started. Leave the year, month and/or day blank when they cannot be estimated or are unknown.

Radiation: (Reportable Field) Check appropriate box. If yes, complete modality type, volume, and number of treatment information as well as the date the radiation started and ended. Leave the year, month and/or day blank when they cannot be estimated or are unknown.

Hormone/Other Therapy: (Reportable Field) Check appropriate box. If yes, complete type, duration information and date hormone therapy started. Leave the year, month and/or day blank when they cannot be estimated or are unknown.

Referred to Hospital or other Physician for this cancer? (Reportable Field) Check appropriate box. If yes, indicate the hospital and/or physician the patient was referred to.