



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

## CANCER REPORTING FORM

Reporting Facility Name:		NPI:	
Reporting Physician Name:		NPI:	
Address:			
City:	State:	Zip:	Phone:
<b>PATIENT DEMOGRAPHIC INFORMATION</b>			
Patient's Last Name:	First:	Middle:	Maiden:
SSN:	DOB:	Birth State:	Birth Country: <input type="checkbox"/> USA <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Primary Payer: <input type="checkbox"/> Insured <input type="checkbox"/> Not Insured <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Self-Pay <input type="checkbox"/> VA <input type="checkbox"/> Military <input type="checkbox"/> Indian/Public Health Services			
Race (Mark all that apply): <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____			Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Address Street:		City:	State: Zip:
Occupation:	Industry:	Date of Last Contact:	Vital Status: <input type="checkbox"/> Dead <input type="checkbox"/> Alive Evidence of Tumor: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>CANCER AND STAGING INFORMATION</b>			
Date of Diagnosis:	Tumor Site:	Laterality: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> Unknown	Tumor Size (Millimeters): Histology (Type of cancer):
Diagnostic Confirmation: <input type="checkbox"/> Histology <input type="checkbox"/> Cytology <input type="checkbox"/> Microscopic <input type="checkbox"/> Lab test <input type="checkbox"/> Visual <input type="checkbox"/> X-ray <input type="checkbox"/> Clinical <input type="checkbox"/> Unknown			
TNM Staging: <input type="checkbox"/> Clinical <input type="checkbox"/> Pathological <input type="checkbox"/> Unknown T _____ N _____ M _____ Stage Group _____			
<b>Please attach copies of surgical or pathology report if necessary</b>			
<b>TREATMENT INFORMATION (MARK ALL THAT APPLY)</b>			
Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Procedure Name:		Date:
Chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Agents, duration:		Date Started:
Radiation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Modality Type, Volume, and Number of Treatments:		Date Started:
			Date Ended:
Hormone/Other Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Type, duration:		Date Started:
Referred to Hospital or other Physician for this cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Name:		
	Physician Name:		

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