Missouri Cancer Registry Cancer Reporting Form (CRF)

Be sure to attach copies of all Op notes, Path, Tx summary or Imaging reports and return with completed form via fax: 573.884.9655

PHYSICIAN/FACILITY INFORMATION

Practice Name:	Physician Name:	Phone number:	NPI#:
Street Address:	City:	State:	Zip Code:

PATIENT INFORMATION

Patient Last Name:	Middle Name or Initial:	First Name:	
Street Address: (please be sure to include *address*)	City:	State:	Zipcode:
SSN:	DOB: (MM/DD/YYYY)	Primary Payer at Diagnosis: ☐ Not insured ☐ Medicaid ☐ Military ☐ Unknown ☐ Medicare w/ supplement ☐ Medicare w/o supplement ☐ Self pay ☐ Insured, NOS	

PATIENT DEMOGRAPHICS/CANCER IDENTIFICATION/STAGING/TREATMENT

Race:
☐ White ☐ African American
☐ Hispanic/Other (please specify) ______

Sex:
☐ Male ☐ Female
☐ Other (please specify) ______

Tobacco History: ☐ Yes ☐ No ☐ Past ☐ Unk

Alcohol History: ☐ Yes ☐ No ☐ Past ☐ Unk

Marital Status at Diagnosis:
☐ Married ☐ Divorced ☐ Single
☐ Separated ☐ Unknown ☐ Widowed

Vital Status:
☐ Alive, free of cancer ☐ Alive, evidence of cancer ☐ Alive, cancer status unknown
☐ Deceased, free of cancer ☐ Deceased, evidence of cancer ☐ Deceased, cancer status unknown

Is this a new cancer or a recurrence of a previously diagnosed cancer ? ☐ New ☐ Recurrence

Procedure performed: (attach copies of reports)
Biopsy Date: ______ Biopsy Type: ______

Surgical Procedure Type: ______

Date of Procedure: ______

Primary Site: ______

Date of Diagnosis: ______

Laterality: ☐ Right ☐ Left ☐ Bilateral

Ulceration: ☐ Yes ☐ No

Breslow's information: ______ **Tumor size:** ______

Histology: (cell type) ______

Grade: (select one) ☐ Well ☐ Moderate ☐ Poorly differentiated ☐ Undifferentiated/ Anaplastic

Lymph node involvement: ______ # positive ______ # removed

Pre op Tumor Markers:

Prostate (PSA):		Breast (ER):		Testis (AFP):	
Prostate (Gleasons/ Bx):		Breast (PR):		Testis (hCG):	
Prostate (Gleasons/ TURP):		Breast (HER2):		Testis (LDH):	

SEER Staging of Disease:
☐ In situ ☐ Local ☐ Regional*
☐ Distant* ☐ Unknown*

TNM: ______

Staging procedures: (attach copies of reports)

MRI Date:	☐ Positive	☐ Negative	☐ Unk
Bone Scan Date:	☐ Positive	☐ Negative	☐ Unk
CT Scan Chest Date:	☐ Positive	☐ Negative	☐ Unk
CT Abd/Pelvis Date:	☐ Positive	☐ Negative	☐ Unk
Radiograph/(other) Date:	☐ Positive	☐ Negative	☐ Unk

Distant metastasis: ______ Use these codes for distant metastasis: 0-None, 1-Peritoneum, 2-Lung, 3-Pleura, 4–Liver, 5-Bone, 6-CNS, 7-Skin, 8-LN (distant)

Chemotherapy:
Start Date: ______ Agent(s): ______

Hormone Treatment:
Start Date: ______ Type: ______

Radiation Treatment:
Start Date: ______

Radiation Modality:
☐ External beam ☐ Brachytherapy
☐ Other (specify) ______

Other Treatment:

Other relevant information (providers/referrals, etc., previous history of other cancer(s)/conditions(s):

Date of Last Contact or Death (MM/DD/YYYY)

FOLLOW BACK INFORMATION

Person completing form:	Date:	Contact information (fax and email):