

INSTRUCTIONS FOR COMPLETING THE CANCER REPORTING FORM (CRF)

The Delaware Cancer Registry (DCR) appreciates your cooperation in complying with data submission requirements for reportable diseases. Every attempt is made to streamline the reporting process and to minimize follow-up contacts with reporting facilities. The following instructions are included to clarify those data items that are commonly left blank or incorrectly coded. **Please observe the following instructions to avoid additional data request calls from the DCR.**

GENERAL INSTRUCTIONS

- a) Complete a CRF for *each* patient **your facility** diagnosed with or treated for a reportable disease. Do NOT assume that a hospital or other clinician your facility referred a patient to will submit the data.
- b) Include pathology/cytology reports with the completed CRF. If these reports are not in your patient records then be sure to note that under COMMENTS.

PRACTITIONER IDENTIFICATION

1. **Practitioner/Facility Name** – Indicate the name of the attending clinician/facility that is reporting a cancer diagnosis/treatment.
2. **Person completing form** – Indicate the name of the person completing the CRF.

CASE IDENTIFICATION

1. **Sex** – Indicate patient's sex at birth.
2. **Race 1, 2** – Indicate the appropriate race group(s) the patient belongs to.
3. **Ethnicity** – Indicate whether the patient is of Spanish/Latin descent.
4. **Patient's Usual Occupation** - Indicate what job the patient worked for the majority of his/her career, regardless of whether patient is currently retired. For example, if the patient delivered the US mail for 30 years but is now retired then enter "postal carrier" as the occupation, not "retired".
5. **Company or Industry** – Indicate the patient's employer or the kind of business the patient worked in.

INSTRUCTIONS FOR COMPLETING THE CANCER REPORTING FORM (CRF)

CANCER IDENTIFICATION

1. **Date of Initial Diagnosis** – For a specimen sent to pathology, indicate the date the specimen was COLLECTED, not the date that pathology returned a positive diagnosis.
2. **Place of Diagnosis** – Indicate the facility/office where the specimen was collected (e.g., name of physician's office or ambulatory surgery center).
3. **Primary Cancer Site** – Indicate where the cancer originated (e.g. breast, prostate, bone marrow, skin)
4. **Histology** – Indicate the type of tissue involved (e.g. adenocarcinoma, acute lymphocytic leukemia, melanoma)
5. **Laterality** – Indicate which side of organ is involved with cancer - for example: right breast, skin of mid-back, left and right lung, left kidney.
6. **Diagnostic Confirmation** – Indicate what process/procedure(s) was used to substantiate the cancer diagnosis.
7. **Summary Stage** – Indicate the stage of the cancer.

CANCER DIRECTED 1ST COURSE OF TREATMENT

1. Indicate what treatment(s) the patient has undergone. Be sure to include the date the treatment began.
2. **Type** – Indicate the *name* of the surgical procedure, drug, or therapy the patient underwent and the amount received. Also, no treatment is a form of treatment. Be sure to indicate when the treatment plan is either watchful waiting or when the patient refuses treatment.
3. **Date of Last Contact (or Death)** – Indicate when your facility last saw the patient. **If the patient has expired** then provide the date of death and circle the word “Death”.
4. **Evidence of Cancer at Last Visit?** – Indicate whether the patient was cancer free at last visit.
5. **Patient Referred From** – Indicate the name and specialty of the physician that sent the patient to your facility.
6. **Patient Referred To** – Indicate the name and specialty of the physician. Also provide the name of the facility if applicable.

DELAWARE CANCER REGISTRY REPORTING FORM

Revised February 2011

Instructions:

1. Please type or print clearly.
2. Complete this form for *each* cancer diagnosed.
3. Mail/fax completed form along with pathology report and any supporting documentation to:

DELAWARE CANCER REGISTRY

256 CHAPMAN ROAD
OXFORD BUILDING, SUITE 100
NEWARK, DE 19702

Phone: (302) 283-7200

Fax: (302) 283-7201

PRACTITIONER IDENTIFICATION

Practitioner/Facility Name: _____ Practitioner/facility # _____

Phone: _____ Address: _____

Person completing form: _____ Date Form Completed: _____

CASE IDENTIFICATION

Patient's Last Name: _____ First Name: _____ MI: _____

Sex: Male Female Soc. Sec. #: _____ - _____ - _____ Date of Birth (MM-DD-YYYY): _____ - _____ - _____

Marital Status: Single Married Divorced Widowed Unknown

Race 1	Race 2
<input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/ Alaskan native <input type="checkbox"/> Asian (specify) _____ <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/ Alaskan native <input type="checkbox"/> Asian (specify) _____ <input type="checkbox"/> Other (specify) _____

ETHNICITY - Hispanic/Latin Origin: No Yes Specify if yes: _____

Patient's usual occupation: _____ Company or Industry: _____

Patient's address at time of diagnosis: Street: _____ City: _____

State: _____ Zip Code: _____ Place of Birth: _____

CANCER DIAGNOSTIC DATA

Date of Initial Diagnosis: _____ Place of Diagnosis (office/facility name): _____

Primary Cancer Site: _____ Histology: _____ Grade: _____

Laterality: Left Mid Right If Melanoma: Ulceration present? Yes No Tumor Depth: _____ mm

Diagnostic Confirmation (Check all that apply)

- Histology/pathology Cytology Radiology Lab Test/Marker Study Endoscopy
 Immunophenotyping Genetic studies Clinical diagnosis Others (specify) _____

Findings: _____

Staging

Summary Stage: In situ Localized Regional, direct extension Regional lymph nodes Distant Unknown

AJCC Stage: T _____ N _____ M _____ Stage _____ Residual Tumor: _____

CANCER DIRECTED FIRST COURSE OF TREATMENT

_____ Watchful Waiting: Date _____ Patient Refused TX: Date _____

Surgery	Chemotherapy	Radiation Therapy	Hormone Therapy	Other Therapy
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Type: _____	Type: _____	Type: _____	Type: _____	Type: _____

Patient status: Alive Dead Unknown Date of last contact (or death): _____

Evidence of cancer at last visit? Yes No Patient Referred From: _____

Patient Referred To: _____ Comments: _____



DELAWARE CANCER REGISTRY REPORTING FORM for Ambulatory Surgery Centers

Instructions:

- 1. Print clearly or type.
2. Complete this form for each cancer diagnosed.
3. Mail/fax completed form along with pathology report and any supporting documentation to:

DELAWARE CANCER REGISTRY
256 CHAPMAN ROAD
OXFORD BUILDING, SUITE 100
NEWARK, DE 19702

Phone: (302) 283-7200
Fax: (302) 283-7201

PRACTITIONER IDENTIFICATION

Practitioner Name: Phone:
Practitioner Address:
Person completing form: Date Form Completed:

CASE IDENTIFICATION

Patient's Last Name: First Name: Middle Initial:
Sex: Male Female Social Security #: Date of Birth:
Marital Status: Single Married Divorced Widowed Unknown

Table with 2 columns: Race 1, Race 2. Rows include checkboxes for African American, White, American Indian/Alaskan native, and Asian/Other (specify).

ETHNICITY - Hispanic/Latino Origin: No Yes Specify if yes:

Patient's address at time of diagnosis: Street:
City: State: Zip Code:
Patient's usual occupation: Company or industry:

CANCER DIAGNOSTIC DATA (please attach pathology report): Date of Initial Diagnosis:

Place of Diagnosis (office/facility name):
Primary Site of Cancer: Histology:
Grade: Laterality: Left Mid Right

Patient Referred From:

Patient Referred To:

If available, please note any additional information on stage of cancer and first course of treatment:

Four horizontal lines for providing additional information on cancer stage and treatment.