ACR CANCER REPORTING FORM FOR HEALTH CARE PROVIDERS

Instructions: Complete this form on each patient diagnosed with and/or treated for a reportable cancer. A **separate** form must be completed for each primary tumor.

REPORTING HEALTH CARE PROVIDER **Telephone:** **Fax:**

FORM COMPLETED BY (Name) **DATE COMPLETED**

NAME OF PROVIDER OR FACILITY PATIENT REFERRED TO (IF ANY) **(i.e., Oncology, Radiation Oncologist, Surgeon)**

PATIENT'S NAME (Last) (First) (Middle) (Maiden or Aliases)

PATIENT'S ADDRESS AT DIAGNOSIS (Street, City, State, Zip Code)

SOC. SEC. #

DATE OF BIRTH M M D D Y Y

MARITAL STATUS (Check one)
☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Unknown

RACE (Check one)
☐ White ☐ Black
☐ Am. Indian/AK Native ☐ Asian/Pacific Islander
☐ Other _____ (specify)
☐ Unknown

ETHNIC TYPE (Check one)
☐ Non-Hispanic
☐ Hispanic _____ (specify)
☐ Unknown

SEX (Check one)
☐ Male
☐ Female

DATE OF DIAGNOSIS M M D D Y Y **DATE OF FIRST CONTACT** M M D D Y Y **DATE OF LAST CONTACT** M M D D Y Y **DIAGNOSING FACILITY/OFFICE:**

PRIMARY SITE

HISTOLOGIC CELL TYPE **TUMOR GRADE**

PAIRED ORGAN/LATERALITY (Check one): ☐ Not app. ☐ Right ☐ Left ☐ Both ☐ Side not specified ☐ Unknown

DIAGNOSTIC CONFIRMATION (Check one)
☐ Histology ☐ Cytology ☐ Micro-confirmed (method not specified) ☐ Direct Visualization
☐ Clinical diagnosis only ☐ Radiography ☐ Lab test/marker study ☐ Unknown

TUMOR SIZE (mm)

STAGE OF DISEASE AT DIAGNOSIS (Check one)
☐ In Situ ☐ Regional, Direct Extension ☐ Regional, Direct Extension & Lymph Node ☐ Distant
☐ Local ☐ Regional, Lymph Node ☐ Regional, NOS ☐ Unstaged

FIRST COURSE OF TREATMENT (i.e., treatment that modifies, controls, removes or destroys cancer tissue)
(Check all that apply): ☐ None ☐ Patient refused treatment ☐ Diagnostic procedure only ☐ Palliative only
☐ Excisional Biopsy ☐ Laser surgery ☐ Cryosurgery ☐ Surgery, NOS
☐ Radiation ☐ Chemotherapy ☐ Hormone therapy ☐ Immunotherapy
☐ Other (specify): _____

DATE THERAPY INITIATED (if known): _____

DID THE PATIENT GO OUT-OF-STATE FOR THERAPY: ☐ Yes ☐ No IF YES, WHICH STATE:

Fam. Hist. of Cancer (Check): ☐ None ☐ Sibling ☐ Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Spouse ☐ Child ☐ Unk.

Smoking History (Check):
☐ Non-smoker ☐ Smoker ☐ Cigar/pipe ☐ Chew/snuff ☐ Quit ☐ Unknown

Tot. Yrs. Smoking

Packs/Day

Note: Please submit supporting text/documentation (e.g., pathology reports/radiology findings/pre-operative H&P), to verify diagnosis, staging, histology, treatment, etc. **Please mail this form and documentation to: Alaska Cancer Registry, Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion, 3601 C St. Suite 722, Anchorage, AK 99503-5934.** If you have any questions, please contact ACR at **(907) 269-2020 or (888) 933-7874; Fax: (907) 561-1896.** Thank you for your cooperation.