

ARIZONA CANCER REGISTRY MELANOMA REPORT FORM



THE GRAY SHADED AREAS MUST BE COMPLETED EVEN IF THE DEMOGRAPHIC OR PATH REPORT IS ATTACHED.

REPORTING FACILITY (Name, Address, and Phone Number)		REPORTING PHYSICIAN	
IF Dx ELSEWHERE: Facility name/place		<input type="checkbox"/> NOT MY PATIENT Attending physician name/contact information:	
PATIENT IDENTIFICATION			
PATIENT NAME (Last), (First) (Middle) (Maiden or Aliases)			
PATIENT'S ADDRESS AT DIAGNOSIS (Street, City, State, Zip Code) <i>MAY ATTACH COPY OF DEMOGRAPHIC REPORT</i>			
PATIENT'S CURRENT ADDRESS (Street, City, State, Zip Code)			
SOCIAL SECURITY #:	DATE OF BIRTH: (mm/dd/yyyy)	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	RACE : (check one) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown HISPANIC ORIGIN: (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
			DOES PATIENT HAVE HISTORY OF OTHER CANCER? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, what type & when diagnosed?
PATIENT'S USUAL INDUSTRY:		USUAL OCCUPATION:	
CANCER IDENTIFICATION <i>ATTACH COPY OF PATH REPORT</i>		STAGE OF DISEASE	
DATE OF DIAGNOSIS: (mm/dd/yyyy)		DESCRIPTION OF EXTENSION: <i>IF PATH REPORT ATTACHED NO NEED TO COMPLETE DESCRIPTION OF EXTENSION.</i>	
PRIMARY SITE : (with description, i.e. skin, right lower arm)		Measured Thickness (depth) of Tumor (Breslow's): _____mm	
LATERALITY: (designate right or left, check one) <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Midline <input type="checkbox"/> Unknown		Clark Level: <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III <input type="checkbox"/> Level IV <input type="checkbox"/> Level V	
SUBTYPE: (Type of melanoma, i.e. superficial spreading melanoma)		Ulceration: <input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Not Reported	
CLINICAL DIAMETER OF MELANOMA: (In millimeters)		Mitotic Count: <input type="checkbox"/> Absent <input type="checkbox"/> Present/Rate _____ <input type="checkbox"/> Not Reported	
SURGICAL DIAGNOSTIC PROCEDURE: Biopsy: <input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Excisional Biopsy <input type="checkbox"/> Incisional		DESCRIPTION OF INVASION INTO THE LAYERS OF THE DERMIS, IF CLARK LEVEL NOT REPORTED	
TREATMENT (1st Course) <i>ATTACH COPY OF PATH REPORT</i>		DIAGNOSTIC CONFIRMATION: <input type="checkbox"/> Histology <input type="checkbox"/> Cytology <input type="checkbox"/> Other (specify) _____	
SURGICAL RESECTION: (insert margins by surgery indicated) <input type="checkbox"/> Wide Local Tumor Excision – With _____cm margin <input type="checkbox"/> Staged Excision (Slow Mohs) – With _____cm margin <input type="checkbox"/> Other (specify) _____ Date (mm/dd/yyyy) _____		REGIONAL LYMPH NODES: (Regional lymph node involvement) Clinical palpable nodal adenopathy: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unk Histologic nodal involvement: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unk Sentinel Lymph Node Biopsy: <input type="checkbox"/> Neg <input type="checkbox"/> Pos Date: (mm/dd/yyyy) _____	
Residual Tumor at Time of Surgery (if applicable): <input type="checkbox"/> Yes <input type="checkbox"/> No		Lymph Node Dissection: <input type="checkbox"/> Neg <input type="checkbox"/> Pos Date: (mm/dd/yyyy) _____	
TYPE OF Tx AFTER SURGERY: (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Hormone <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____ Date: (mm/dd/yyyy) _____ Where Performed: _____		IF NODAL INVOLVEMENT, INDICATE WHICH BASINS POSITIVE	
FOLLOW-UP		DISTANT INVOLVEMENT AT TIME OF DX: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
PATIENT STATUS: (check one) <input type="checkbox"/> Alive <input type="checkbox"/> Expired As of what date? (mm/dd/yyyy) _____		IF YES, INDICATE SITES	
CANCER STATUS: (check one) <input type="checkbox"/> No evidence <input type="checkbox"/> Evidence <input type="checkbox"/> Unknown			
FOLLOW-UP PHYSICIAN: (First) (Last)			

Return Completed Form To:

ARIZONA CANCER REGISTRY
150 N. 18th Avenue, Suite 550
Phoenix, Arizona 85007

Questions: Voice (602) 542-7320
Fax (602) 542-7362