

CTR & ID # (ACR USE ONLY)					ARIZONA CANCER REGISTRY				
					ARIZONA DEPARTMENT OF HEALTH SERVICES				
PHYSICIANS, DENTISTS & FREESTANDING OUTPATIENT CLINICS REPORT FORM									
REPORTING FACILITY (NAME, ADDRESS, AND PHONE NUMBER)									
PATIENT NAME (Last)		(First)		(Middle)		(Maiden or Aliases)			
PATIENT'S ADDRESS AT DIAGNOSIS (Street, City, State, Zip Code)									
PATIENT'S CURRENT ADDRESS (Street, City, State, Zip Code)									
DATE OF 1ST CONTACT W/ PATIENT FOR THIS CANCER			PATIENT'S USUAL INDUSTRY				USUAL OCCUPATION		
MM / DD / YYYY									
CHART NUMBER		SOCIAL SECURITY NUMBER		DATE OF BIRTH		DOES PATIENT HAVE Hx OF OTHER CA.? IF YES, WHAT & WHEN Dx?			
		- -		MM / DD / YYYY					
RACE (check one)				HISPANIC (check one)		SEX (check one)			
<input type="checkbox"/> Caucasian/White <input type="checkbox"/> Black <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Am. Indian (Tribe):				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Transsexual <input type="checkbox"/> Unknown			
DATE OF DIAGNOSIS			IF Dx ELSEWHERE (Facility name/place)			PRIMARY SITE & SUBSITE		TUMOR SIZE (In millimeters)	
MM / DD / YYYY									
CELL TYPE (Histology)			GRADE (Check one)				FOR LEUKEMIA & LYMPHOMA (Check one)		
			<input type="checkbox"/> Grade I (Well diff.) <input type="checkbox"/> Grade II (Mod. diff.) <input type="checkbox"/> Grade III (Poorly diff.) <input type="checkbox"/> Grade IV (Undiff.) <input type="checkbox"/> Not determined, not stated, not applicable				<input type="checkbox"/> T-Cell <input type="checkbox"/> B-Cell, pre-B <input type="checkbox"/> Null, non T-non B		
EXTENT AT DIAGNOSIS (Stage)			SUBSTANTIATE EXTENT AT Dx (Stage)			DISTANT Involvement(s) at time of Dx (circle up to 3)			
<input type="checkbox"/> In Situ <input type="checkbox"/> Local <input type="checkbox"/> Regional Ext. <input type="checkbox"/> Reg. Node <input type="checkbox"/> Reg. Ext & Node Inv. <input type="checkbox"/> Distant <input type="checkbox"/> Unknown						0 None 4 Liver 8 Distant lymph nodes 1 Peritoneum 5 Bone 9 Other, Unknown 2 Lung 6 CNS 3 Pleura 7 Skin			
PAIRED ORGAN (check one)			DIAGNOSTIC CONFIRMATION (check one)				OPTIONAL TNM		
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> Unknown <input type="checkbox"/> None			<input type="checkbox"/> Histology <input type="checkbox"/> Cytology <input type="checkbox"/> Clinical <input type="checkbox"/> X-Ray <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Please specify) IF AVAILABLE PLEASE ATTACH COPY OF PATH REPORT				Basis (C/P) ___ T ___ N M STAGE GROUP:		
TREATMENT (1st Course)		TYPE OF Tx		DATE		WHERE PERFORMED		RESIDUAL TUMOR	
								<input type="checkbox"/> Yes <input type="checkbox"/> No	
PATIENT STATUS (check one) Date: MM/DD/YYYY					CANCER STATUS (check one)				
<input type="checkbox"/> Alive: As of what date? <input type="checkbox"/> Expired: As of what date?					<input type="checkbox"/> No evidence <input type="checkbox"/> Evidence <input type="checkbox"/> Unknown				
IF EXPIRED, PLACE OF DEATH					CAUSE OF DEATH				
FOLLOW-UP PHYSICIAN (FIRST) (LAST)					SECOND PHYSICIAN (FIRST) (LAST)				
FORM COMPLETED BY:					DATE COMPLETED:				
Return Completed Form To:					ARIZONA CANCER REGISTRY 150 N. 18th Avenue, Suite 550 Phoenix, Arizona 85007			Questions Call 602/542-7320 c:\dh\physicianreportform.doc	