

North Carolina Central Cancer Registry

Department of Health and Human Services
Division of Public Health
State Center for Health Statistics



Cancer Incidence Reporting Form

PATIENT INFORMATION

Patient's Name: Last		First		Middle	
ADDRESS AT TIME OF DIAGNOSIS:	SSN:	Sex:			
Street		<input type="checkbox"/> Male <input type="checkbox"/> Female			
City	Date of Birth: MM/DD/YY	Race			
State	Primary Payer(s) at DX:	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian			
Zip	Patient's County of Residence at DX:	<input type="checkbox"/> Other (please specify) _____			
		If Patient is of Hispanic Origin, Please List Type (Mexican, Puerto Rican, Cuban, etc.) _____			

CANCER DIAGNOSIS

Date of Diagnosis: MM/DD/YY	Primary Site:	Laterality: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Midline <input type="checkbox"/> N/A	Vital Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead
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Pathology/Laboratory Findings Diagnosing Cancer (please attach copies of initial and final path reports):

Surgical treatment for this cancer (please attach copies of operative notes for biopsy and/or definitive treatment, to include any lymph node biopsy):

Other treatment therapy for this cancer: (you may attach copies of treatment summaries):

Radiation	Hormone	Chemo	Immuno	Hematologic	Endocrine
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Type: _____	Type: _____	Type: _____	Type: _____	Type: _____	Type: _____
Dose: _____	Dose: _____	Dose: _____	Dose: _____	Dose: _____	Dose: _____
Other: (Please Specify) _____ Type: _____ Dose: _____ Date: _____					

X-Ray/Scans Findings relevant to the diagnosis or treatment of this cancer (CXR, MRI, CT, PET, etc., please attach copies):

If patient was referred to another facility or doctor for treatment, please list name referred to:

If patient was referred from another facility for diagnosis and/or treatment, please list name of referring facility or doctor:

Does patient have a prior history of cancer? (Include cancer of any histology; please list site, histology and date of diagnosis if available, exclude basal cell carcinoma and squamous cell carcinoma of the skin):

Name of individual completing this form: _____
Date: _____ Facility Name: _____

Please mail your completed form to the designated address below:
 NCCCR • 222 N. Dawson Street • Raleigh, NC 27603 • Phone # (919) 715-0650 • Fax # (919) 715-7294
 Venita Brannigan • NCCCR • 225 Green Street - Suite 904 • Fayetteville, NC 28301 • Phone # (910) 486-4013 • Fax # (910) 829-6458