

# North Carolina Central Cancer Registry

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



## Cancer Incidence Reporting Form Melanoma

### PATIENT INFORMATION

Patient's Name: Last First Middle

ADDRESS AT TIME OF DIAGNOSIS:

Street

SSN:

Sex:

Male  Female

City

Date of Birth: MM/DD/YY

Race

White  Black  American Indian

State

Primary Payer(s) at DX:

Other (please specify) \_\_\_\_\_

Zip

Patient's County of Residence at DX:

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:

Right  Left  Midline

Vital Status:

Alive  Dead

Pathology Findings (please attach copies of initial and final path reports):

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

Shave/Punch Bx

Excisional Bx

Wide Excision

Re-excision

Mohs Surgery

Other

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

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

Tumor Size (actual tumor size/lateral dimension):

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

If patient was referred from another facility for diagnosing 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 BCC/SCC of the skin):

Name of individual completing this form: \_\_\_\_\_

Date: \_\_\_\_\_

Please mail your completed form to the designated address below:

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