Instructions for Missouri Cancer Registry
Cancer Reporting Form

Physician/Facility Information
-Practice Name: Record full name of the facility/practice reporting the cancer information including Physician name.

Patient Information
-Full last name, middle initial and first name. Note any aliases or nicknames.
-Residence address at time of diagnosis.
-Social security number: Do *not* use a spouse's social security number.
-Primary payer at diagnosis: Check insurance type

Patient Demographics
-Check the box that best describes the patient's race. Hispanic/Spanish ethnicity: Check if patient is of Hispanic/Spanish origin. See manual for additional instructions.
-Indicate patient's history of tobacco and alcohol use.
-Record the patient's marital status.
-Vital status: Check one

*****Please provide *dates* where indicated. If actual date is unknown please provide an estimated date based on your admission records. *** This might be clinical, radiological or based on a Pathological report.**

Cancer Identification/Staging/Treatment
-New or Recurrence: If this is the first time the patient has been diagnosed with this cancer, choose New. If this is a recurrence of previously diagnosed cancer, choose Recurrence.
-Procedures Performed: Document the type of procedure that was performed to diagnose the patient's cancer. Record the date of the procedure.
-Surgical Procedure Type: Document the surgical procedure that was performed. Record the date of the surgical procedure.
-Primary Cancer site: Record the cancer based on location of cancer (i.e. breast, colon, etc.).
-Date of Diagnosis: Record the Date of Diagnosis.
-Laterality: If the cancer occurred in a paired organ, indicate whether right, left or bilateral.
-Ulceration: Ulceration is the breakdown of the skin over the melanoma. Record any information given regarding ulceration located in the path report.
-Breslow's information: For melanoma cases, record thickness of the tumor in millimeters.
https://www.oncolink.org/cancers/skin/melanoma/treatments/understanding-your-pathology-report-melanoma
-Record the tumor size: Record tumor size in millimeters.
-Histology (cell type): This information may be found on the pathology report. Histology describes the type of cancer cell (adenocarcinoma, squamous, etc.)
-Grade: Choose one. This can be found on the path report.
-Lymph node involvement: Record # positive / # removed: Ex: 4/10
-Pre Op Tumor Markers: Add value if known.
-SEER Staging of Disease: https://training.seer.cancer.gov/staging/systems/
-TNM: https://www.cancer.org/cancer/melanoma-skin-cancer/detection-diagnosis-staging/melanoma-skin-cancer-stages.html
-Staging procedures: Attach copies of reports, if available.
-Distant metastasis: If cancer has spread to other sites beyond the primary site, record the site to which it has spread.
-Chemotherapy: List agents and dates for any known chemotherapy given.
-Hormone Treatment: List start date and type of hormone treatment given.
-Radiation Treatment: List start date for any radiation treatment given.
-Radiation Modality: Choose type of radiation given. If not listed, choose Other and specify.
-Other Treatment: Document the type of treatment the patient received. Include the procedure name and the place the procedure was performed.
-Other relevant information (previous history of other cancer(s)/condition(s): Document any other relevant information regarding previous history of other cancer(s) and/or conditions(s) if known. This can include primary care physicians and specialty physicians such as urologist, dermatologist, etc.
-Date last contact: Record the last time the patient was seen by your facility.