Missouri Cancer Registry LTCF Reporting Form

Be sure to attach copies of all relevant chart information and return with completed form via fax: 573.884.9655

Physician/Facility Information

Facility Name:	Facility type:	Phone number:	NPI#:
Street Address:	**City:**	**State:**	**Zip Code:**
		Missouri	

Patient Information

Patient Last Name:	Middle Initial:	First Name:	
Patient Street Address: (PLEASE BE SURE TO INCLUDE ***PATIENT*** ADDRESS ONLY)	City:	State:	Zip code:
		Missouri	
SSN:	DOB:	Primary Payer at Diagnosis:	
		○ Not insured ○ Medicaid ○ Military ○ Unknown ○ Medicare w/ supplement ○ Medicare w/o supplement ○ Self pay ○ Insured, NOS	

Patient Demographics

Race:
○ White ○ African American
○ Hispanic/Other (please specify)

Sex:
○ Male ○ Female
○ Other (please specify)

Tobacco History: ○ Yes ○ No ○ Past ○ Unk

Alcohol History: ○ Yes ○ No ○ Past ○ Unk

Marital Status at Diagnosis:
○ Married ○ Divorced ○ Single
○ Separated ○ Unknown ○ Widowed

Vital Status:
○ Alive, free of cancer ○ Alive, evidence of cancer ○ Alive, cancer status unknown
○ Deceased, free of cancer ○ Deceased, evidence of cancer ○ Deceased, cancer status unknown

Usual or longest held occupation

Industry or company of usual or longest held/ known occupation

Date admitted to your facility:

Date of Last Contact or Death (MM/DD/YYYY)

Facility transferred to/from (facility name)

Physician name and phone number

Cancer #1

Is this:
○ A cancer not previously diagnosed
○ A recurrence of a previously diagnosed cancer
○ A history of cancer with no evidence of that cancer
○ A history of cancer with evidence of that cancer

Date of Diagnosis:

Facility/State of Diagnosis:

Primary Site (Site of Diagnosis):

Laterality: ○ Right ○ Left ○ Unknown

Histology:

Treatment: **Date:**

Treatment **Date:**

Cancer #2

Is this:
○ A cancer not previously diagnosed
○ A recurrence of a previously diagnosed cancer
○ A history of cancer with no evidence of that cancer
○ A history of cancer with evidence of that cancer

Date of Diagnosis:

Facility/State of Diagnosis:

Primary Site (Site of Diagnosis):

Laterality: ○ Right ○ Left ○ Unknown

Histology:

Treatment: **Date:**

Treatment **Date:**

Other Relevant Information

Other physicians/facilities directly involved in patient's cancer care:

Other relevant patient information:

Follow Back Information

Person completing form:	Date:	Contact information (EMAIL AND FAX):