

Cancer Notification Form

Oregon State Cancer Registry

Please Print

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CASE IDENTIFICATION (Patient Identifying Information)

Last Name: First Name: MI: Birthdate: Social Security Number: Sex: M F

Physical Street Address NO P.O. BOX, if possible Home Phone: Marital Status: Married Single Divorced Widowed

City: State: Zipcode: County: Race: African American Asian American Indian White Pacific Islander Unknown Ethnicity: Hispanic NonHispana

Occupation:

CANCER DATA (Diagnostic information)

Date of Diagnosis:

Primary Site:

Histology and Grade:

STAGE OF DISEASE

In-situ
 Localized
 Regional, direct extension
 Regional, nodes
 Distant
 Unknown

CANCER DIRECTED TREATMENT

SURGERY: Yes No
Date: _____
Type: _____

CHEMOTHERAPY: Yes No
Date started: _____
Agents: _____

RADIATION THERAPY: Yes No
Date started: _____
What facility: _____

HORMONE THERAPY: Yes No
Date started: _____
Type: _____

OTHER: (Please explain) _____

PRACTITIONER IDENTIFICATION

Telephone: () FAX: ()

Practitioner Name:

Address:

City: State: Zipcode:

Patient referred to:

Person completing form and date completed:

Please mail or fax this form, along with a pathology report (if available) to:

Oregon Health Division
Oregon State Cancer Registry
800 NE Oregon St., Suite 730
Portland, OR 97232
Tel: (971)673-0986
Fax: (971)673-0996
E-mail: oscar.ohd@state.or.us

PATIENT STATUS

Date of last contact/death: _____
(Please circle)
Evidence of tumor at last visit: Yes No
Patient status: Alive Dead

REPORTABLE NEOPLASMS

- Diagnosis date of 1/1/96 or later.
- All invasive malignant neoplasms (ICD 140-208.9), except basal and squamous cell carcinoma of the skin.
- All in situ carcinomas (ICD 230-232.9, 233.0, 233.2-234.9) except carcinoma in situ of the cervix uteri.

NOTE: Practitioners DO NOT need to report any case that is admitted to an Oregon reporting facility for a cancer diagnosis or for all or any part of the first course of therapy for that case within 180 days of diagnosis.

