

# CANCER REPORTING FORM

## Washington State Cancer Registry

March 2023

### CASE IDENTIFICATION (Patient identification information)

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

Physical Street Address: (PO Box ok if no street)  City:  State:  Zip code:  Home Phone:

Usual Occupation (while employed):  Industry:  Race:  African American  Asian  American Indian  White  Pacific Islander  Unknown  Hispanic  Non-Hispanic

Primary Insurance:

### 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

OR

### TNM STAGING

T:   
N:   
M:

### PRACTITIONER IDENTIFICATION

Telephone: ( )  Fax: ( )

Practitioner Name:  NPI #:

Address:

City:  State:  Zip Code:

Patient referred to:

Person completing the form and date completed:

### CANCER DIRECTED TREATMENT

Biopsy: Physician: \_\_\_\_\_  
Biopsy Type: \_\_\_\_\_  
Date: \_\_\_\_\_  
Facility Name: \_\_\_\_\_  
Surgery: Yes  No   
Date: \_\_\_\_\_  
Type: \_\_\_\_\_  
Facility Name: \_\_\_\_\_  
Chemotherapy: Yes  No   
Date Started: \_\_\_\_\_  
Agents: \_\_\_\_\_  
Facility name: \_\_\_\_\_  
Radiation Therapy: Yes  No   
Date Started: \_\_\_\_\_  
Type: \_\_\_\_\_  
Facility name: \_\_\_\_\_  
Hormone Therapy: Yes  No   
Date Started: \_\_\_\_\_  
Type: \_\_\_\_\_  
Facility Name: \_\_\_\_\_  
Other: (Please Explain) \_\_\_\_\_  
\_\_\_\_\_

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

Washington State Cancer Registry  
243 Israel Road SE  
PO Box 47855  
Tumwater, WA 98504-7855

Tel: 360-236-3618  
Fax: 360-359-7954  
Email: WSCR@doh.wa.gov

### REPORTABLE NEOPLASMS

- Diagnosis date of 01/01/92 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, 2-234.9) except carcinoma in situ of the cervix uteri.
- All intra-cranial and CNS neoplasm structures are reportable including benign.

### PATIENT STATUS

Alive/Deceased: \_\_\_\_\_  
Date of Last Contact: \_\_\_\_\_  
Status of Tumor: \_\_\_\_\_  
Evidence: \_\_\_\_\_ No Evidence \_\_\_\_\_ Unk \_\_\_\_\_

\*\*\*Include a copy of all pathology reports related to the patient's diagnosis, including re-excisions with no evidence of residual malignancy.