**REPORTER IDENTIFICATION**

FACILITY NAME: ABSTRACTOR INITIALS:

PHYSICIAN’S NATIONAL PROVIDER ID (NPI) #:

FACILITY ID # (Assigned by MCR, if known) :

MEDICAL RECORD # (if applicable):

**PATIENT** **DEMOGRAPHICS**

PATIENT NAME:

SOC SEC #: DATE OF BIRTH: / /

 YYYY MM DD

Patient Residential Address:

Patient Residential Address:

City/State/Zip: , ,

County of Residence:

**GENDER (check one):** **[ ]** Male [ ]  Female [ ]  Other **PLACE (Country or U.S. State) OF BIRTH** (if known):

**RACE** (check one): [ ]  White [ ]  Black [ ]  American Indian [ ]  Asian Indian

[ ]  Asian/Pacific Islander (specify country if known)

[ ]  Other, specify [ ]  Unknown

**SPANISH/HISPANIC ORIGIN** (include country of origin if Hispanic): [ ]  Hispanic/Latino

[ ] Non-Hispanic [ ] Unknown

**OCCUPATION:**

**DIAGNOSIS/TUMOR INFORMATION *PLEASE ATTACH A COPY OF THE PATHOLOGY OR CYTOLOGY REPORT***

**Date of Initial Diagnosis**: / /

 YYYY MM DD

**Site of Tumor**:

**Size of Tumor** (enter tumor size in cm): ●

**Type of Tumor (Histology)**:

**Behavior**: [ ]  Benign [ ]  Borderline Tumor [ ]  In-situ [ ]  Malignant [ ]  Unknown

**Grade** (if stated): [ ]  Grade I [ ]  Grade II [ ]  Grade III [ ]  Grade IV [ ]  Unknown/not stated in report

**Metastatic Disease**: [ ]  Yes Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No [ ]  Unknown

**Tumor Characteristics** (for Staging). Check ‘Yes’ box if condition is present and/or described in the pathology report. Check all that apply: **WHO/ISUP Grade** (***transitional/urothelial cell only***):

Non-Invasive Papillary Tumor  [ ]  Yes [ ]  No Date: [ ] Low Grade

Solid/nodule or confined to mucosa [ ]  Yes [ ]  No Date: [ ] High Grade

Carcinoma “*in-situ*”: Flat [ ]  Yes [ ]  No Date: [ ] No pathologic exam of primary site

Lymphovascular Invasion [ ]  Yes [ ]  No Date: [ ] Unknown

Subepithelial connective tissue of bladder or prostatic urethra [ ]  Yes [ ]  No Date:

Superficial Muscle (muscularis propria) (inner half) of bladder and/or distal ureter [ ]  Yes [ ]  No Date:

Deep muscle (muscularis propria) (outer half) of bladder and/or distal ureter

 BUT still contained within bladder wall [ ]  Yes [ ]  No Date:

Muscle (muscularis propria) invaded, NOS of bladder and/or distal ureter [ ]  Yes [ ]  No Date:

Localized, NOS [ ]  Yes [ ]  No Date:

Microscopic extension to perivesical fat/tissues including: Adventitia or Serosa [ ]  Yes [ ]  No Date:

 (mesothelium) or Peritoneum or Periprostatic tissue or Distal periureteral tissue

Macroscopic extension to perivesical fat/tissues including: Adventitia or Serosa [ ]  Yes [ ]  No Date:

 (mesothelium) or Peritoneum or Periprostatic tissue or Distal periureteral tissue

Extension to/through serosa (mesothelium): Peritoneum [ ]  Yes [ ]  No Date:
Extension to perivesical fat/tissues, NOS [ ]  Yes [ ]  No Date:

Extension to the Prostate or Urethra, Ureter (excluding distal ureter) [ ]  Yes [ ]  No Date:

Bladder is "fixed" to the Pubic bone, Rectum, male [ ]  Yes [ ]  No Date:

Extension to the Abdominal wall, Pelvic wall, Sigmoid, Rectum (female) [ ]  Yes [ ]  No Date:
No evidence of primary tumor [ ]  Yes [ ]  No Date:

Other Specify: Date:

**TREATMENT INFORMATION**

Check responses to indicate which procedures were performed. Check as many as apply. If response is ‘Yes’ please indicate date.

**SURGERY**

None; no cancer-directed surgery of primary site **Reason**

 Date:

Local tumor destruction, NOS **(without pathology specimen)** [ ]  Yes [ ]  No Date:

Local tumor excision, NOS (**with pathology specimen**) [ ]  Yes [ ]  No Date:

Photodynamic therapy (PDT) [ ]  Yes [ ]  No Date:

Cryosurgery [ ]  Yes [ ]  No Date:

Laser ablation [ ]  Yes [ ]  No Date:

Laser excision [ ]  Yes [ ]  No Date:

Polypectomy [ ]  Yes [ ]  No Date:

Excisional biopsy (TURBT) [ ]  Yes [ ]  No Date:

Partial Cystectomy [ ]  Yes [ ]  No Date:

Simple/Total/Complete Cystectomy [ ]  Yes [ ]  No Date:

Radical Cystectomy (male only) [ ]  Yes [ ]  No Date:

Pelvic Exenteration, NOS [ ]  Yes [ ]  No Date:

Radical Cystectomy (female only); anterior exenteration [ ]  Yes [ ]  No Date:

Posterior Exenteration [ ]  Yes [ ]  No Date:

Total Exenteration [ ]  Yes [ ]  No Date:

Extended Exenteration [ ]  Yes [ ]  No Date:

Cystectomy, NOS [ ]  Yes [ ]  No Date:

Surgery, NOS [ ]  Yes [ ]  No Date:

Unknown if cancer directed surgery performed [ ]  Yes [ ]  No Date:

Lymph Node Dissection [ ]  Yes [ ]  No Date:

If Lymph Nodes were involved, please describe name of lymph nodes or area, total number examined, and total number positive.

Lymph node region:       Total Number Nodes Examined:       Total Number Nodes Positive:

Size of Metastasis in lymph nodes: Extranodal Extension: [ ]  Yes [ ]  No

Intravesicicular Therapy Type: Immunotherapy[ ]  Chemotherapy[ ]

**OTHER TREATMENT**

**Drug Therapy**

 M-VAC [ ]  Yes [ ]  No [ ] Unknown Date:

 (methotrexate, vinblastine, doxorubicin (Adriamycin), and cisplatin)

 GemCIS (Gemzar w/ Cisplatin) [ ]  Yes [ ]  No [ ] Unknown Date:

 Carboplatin w/ taxane [ ]  Yes [ ]  No [ ] Unknown Date:

 Cytoxan [ ]  Yes [ ]  No [ ] Unknown Date:

5-FU [ ]  Yes [ ]  No [ ] Unknown Date:

Mitomycin-C [ ]  Yes [ ]  No [ ] Unknown Date:

Gemcitabine [ ]  Yes [ ]  No [ ] Unknown Date:

Ifosfamide [ ]  Yes [ ]  No [ ] Unknown Date:

Methotrexate [ ]  Yes [ ]  No [ ] Unknown Date:

Paclitaxel [ ]  Yes [ ]  No [ ] Unknown Date:

Vinblastine [ ]  Yes [ ]  No [ ] Unknown Date:

Doxorubicin (Adriamycin) [ ]  Yes [ ]  No [ ] Unknown Date:

Thiotepa (Thioplex) [ ]  Yes [ ]  No [ ] Unknown Date:

Bacille Calmette-Guerin vaccine (BCG) [ ]  Yes [ ]  No [ ] Unknown Date:

**Radiation Therapy** [ ]  Yes [ ]  No [ ] Unknown Date:       Describe:

**Other Therapy** [ ]  Yes [ ]  No [ ] Unknown Date:       Describe:

**Provide additional Information or if referral information if the patient was referred to another physician for further treatment or care (if available):**

**NAME SPECIALTY \_\_\_\_\_\_\_\_**

**Please: ATTACH AND SEND A COPY OF THE PATHOLOGY/CYTOLOGY REPORT TO THIS MEDICAL RECORD ABSTRACT**

**Mail or Fax report to:**

**Westat, Inc., Maryland Cancer Registry**

**1500 Research Boulevard, TB 150F**

**Rockville, MD 20850-3195**

**Fax: 240-314-2377**

**Questions? Call 1-888-662-0016 or 301-315-5990**