**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**