1500 Research Blvd

WESTAT, INC 1500 Research Blvd, TB 150F

Rockville, MD 20850

**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**:

**Laterality**:  Not a paired organ, not applicable  Right side Left side  One side, Not otherwise specified

Bilateral Involvement  Midline tumor  Unknown

**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

**Tumor Characteristics** (for Staging). Check ‘Yes’ box if condition is present and/or described in the pathology report:

**Ulceration**  Yes  No **Mitotic Rate:** /mm2

**Regression**  Yes  No **Anatomic Clark’s Level:\_\_\_\_\_\_**(I, II, III, IV, greater)

**Clinical Lymph Node Breslow’s Thickness:** (mm)

**Involvement**  Yes  No **LDH Value** (prior to treatment or w/in 6 weeks of Diagnosis):

**Satellite Lesions Present**  Yes  No **Normal LDH Range Upper Limit:**

**Multiple Nodules**  Yes  No **Metastatic Disease**:  Yes  No  Unknown

**In-Transit Metastasis**  Yes  No **Describe Metastatic Site:**

**Level of Invasion** (describe with text):

**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  Yes  No Date:

Biopsy of primary tumor followed by a gross excision of the lesion  Yes  No Date:

Shave biopsy followed by a gross excision of the lesion  Yes  No Date:

Punch biopsy followed by a gross excision of the lesion  Yes  No Date:

Incisional biopsy followed by a gross excision of the lesion  Yes  No Date:

Wide excision or re-excision of lesion  Yes  No Date:

*[NOTE: Margins of excision are 1 cm or more. Margins may be microscopically involved.]*

Radical excision of a lesion, NOS  Yes  No Date:

Mohs surgery, NOS (not otherwise specified)  Yes  No Date:

Mohs surgey with margin of 1 cm or less  Yes  No Date:

Mohs surgery with margin greater than 1 cm  Yes  No Date:

*[NOTE: Margins of excision are greater than 1 cm and grossly tumor free. The margins may be microscopically involved.]*

Sentinel Lymph Node Biopsy/Mapping  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:

**OTHER TREATMENT**

**Drug Therapy**

Interferon-alpha/Interferon  Yes  No Unknown Date:

Interleukin-2  Yes  No Unknown Date:

Dacarbazine (also called DTIC)  Yes  No Unknown Date:

Cisplatin, Vinblastine, and DTIC (This is known as CVD)  Yes  No Unknown Date:

Temozolomide (Temodar)  Yes  No Unknown Date:

Paclitaxel  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**