**REPORTER IDENTIFICATION**

**FACILITY NAME**: **ABSTRACTOR INITIALS**:

**PHYSICIAN’S NATIONAL PROVIDER ID (NPI) #:**

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

**MEDICAL RECORD / RECORD IDENTIFICATION #:**

**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/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/CYTOLOGY* REPORT**

**Date of Initial Diagnosis**: / /

YYYY MM DD

**Diagnostic Confirmation**:  Positive histology  Positive cytology  Positive microscopic confirmation, method not specified

Positive laboratory test/marker study  Direct visualization  Radiology and other imaging techniques

Clinical diagnosis only  Unknown  Other:

**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): ● Centimeters

**Type of Tumor**:

**Behavior**:  Benign  Borderline Tumor  In-situ (non-invasive)  Malignant (invasive)  Unknown

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

**Lymphoma/Leukemia ONLY**:  T-cell  B-cell  Null cell  NK cell

**TREATMENT INFORMATION**

Describe the treatment(s) performed and date(s):

**Surgery of Primary Cancer Site:**  Yes  No Unknown Date:       Describe:

**Regional Lymph Node Surgery**:  Yes  No Unknown Date:       Describe:

**Surgery of a Distant Site:**  Yes  No Unknown Date:       Describe:

**Reason for No Surgery (if applicable):**

**Chemotherapy:**  Yes  No Unknown Date:       Describe:

**Hormone/Steroid Therapy**:  Yes  No Unknown Date:       Describe:

**Immunotherapy**:  Yes  No Unknown Date:       Describe:

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

**Bone Marrow Transplant:**  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**

**COMMENT/Additional Information:**

**Mail or Fax report [DO NOT e-Mail] 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**

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