**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:**

**Myriddian, LLC., Maryland Cancer Registry**

**6711 Columbia Gateway Drive, Suite 475**

**Columbia, MD 21046**

**Fax: 240-833-4111**

**Questions? Call 1-866-986-6575 or 410-344-2851**