**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 email) 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**

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