GUAM CANCER REGISTRY REPORT FORM

Clear Form

Physician Name: _____
Street Address: _____
City, State, Zip Code: _____
Telephone Number: _____

Patient Name (Last, First, Middle Name) | **Date of Birth** | **Sex** | **Social Security Number**

Residential Patient Address at Diagnosis | **Marital Status**

Occupation (Do not write "Retired") | **Industry** | **Race/Ethnicity** | **Ever Served in USA Armed Forces?** ◯Yes ◯No

MUST ATTACH DOCUMENTS TO BACK UP INFORMATION BELOW: E.G. DIAGNOSTIC & TREATMENT REPORTS/SUMMARIES

Primary Site/Laterality of this cancer (ATTACH PATHOLOGY REPORT): _____

Histology Type of this cancer: _____

Date this cancer was FIRST DIAGNOSED: _____ **Month / Day / Year**

Initial visit for this cancer: _____ **Month / Day / Year**

Most recent visit for this cancer: _____ **Month / Day / Year**

METHOD OF DIAGNOSIS

- ◯ Positive histology
- ◯ Positive cytology
- ◯ Autopsy
- ◯ Radiography
- ◯ Clinical
- ◯ Positive lab test marker study
- ◯ Method Unknown

PATIENT STATUS

- ◯ Alive, free of cancer
- ◯ Alive, evidence of cancer
- ◯ Alive, cancer status unknown
- ◯ Deceased, free of cancer
- ◯ Deceased, evidence of cancer
- ◯ Deceased, cancer status unknown

Did this patient receive any treatment for this cancer? ◯Yes ◯No ◯Unknown

If "Yes", please complete the following:

Surgery (specify type) | **Month / Day / Year**

Radiation (specify type, duration) | **Month / Day / Year**

Chemotherapy (specify agents, duration) | **Month / Day / Year**

Hormone/Other Treatment (specify type, duration) | **Month / Day / Year**

Referred to Physician/Hospital: _____ **Name**

Address | **Tel / Fax Number**

Please Return Completed Form To: **Guam Cancer Registry, Cancer Research Center Guam**
Dean Circle House #27, UOG Station, Mangilao, Guam 96923
Fax: (671) 734-2990 **Phone: (671) 735-2988/0129**

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