HOSPITAL CANCER ABSTRACTING FORM

Form TR-003
Revised 06/21

Reporting Hospital	Abstracted By	Date Abstracted	Date Received by MCTR

PATIENT INFORMATION

Facility #	Accession #	Sequence #	Date of First Contact	Medical Record Number	Primary Payer

Name of Patient Last First Middle Maiden Alias | Name of Spouse/Parent

Physical Address No & Street City County State Zip Code | Place of Birth

Social Security Number	Date of Birth	Age	Facility Referred From	Facility Referred To

Race
☐ White ☐ Am. Ind ☐ Black ☐ Asian ☐ Unk ☐ Other

Hispanic Ethnicity
☐ Yes ☐ No ☐ Unk

Sex
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Div ☐ Widow ☐ Sep ☐ Unk

Telephone Number

Tobacco History
☐ Never ☐ Cigarette ☐ Pipe ☐ Chew ☐ e-Cig, Vape, Liquid ☐ Previous Use ☐ Unk

Alcohol History
☐ Yes ☐ No ☐ Previous ☐ Unk

Usual Occupation | Usual Industry

Follow-Up Contact - Name (not spouse) Relationship No & Street City State Zip Code Telephone Number

CANCER INFORMATION

Date of Diagnosis	Primary Site	Laterality	Other Primary Tumors
		☐ Not Paired ☐ Right ☐ Left ☐ Unk	

Place of Diagnosis (if diagnosed elsewhere, please describe place)
☐ This Hospital ☐ Other Hospital ☐ Physician's Office ☐ Describe _____

Diagnostic Confirmation
☐ Histology ☐ Cytology ☐ Microscopic ☐ Lab Test
☐ Visual ☐ X-ray ☐ Clinical ☐ Unknown

Diagnostic Summary (document details of physical evaluation, pathology, scopes, x-rays/scans, and lab tests including date and name of procedure(s), slide #, facility, specimen, histology, grade, behavior, tumor size, extension, surgical margins, LN's involved and examined). Attach copies of surgical or pathology reports and discharge summaries, if necessary.

Staging
Tumor Size in mm _____ Describe Size _____ Extension/Spread _____
Regional Lymph Nodes *Positive* _____ Regional Lymph Nodes *Examined* _____
Sites of Distant Metastases _____ Describe Stage _____

SEER Summary Staging
☐ In-situ ☐ Local ☐ Regional ☐ Distant ☐ Unknown

AJCC Staging
☐ Clinical ☐ Pathological
T _____ N _____ M _____ Stage Group _____

TREATMENT INFORMATION

Cumulative Treatment Summary (document details of biopsy, surgery, radiation, or systemic therapy including dates, places, and types; if no therapy is given, record reason)

OUTCOMES

Status
Date of Last Contact or Death _____
Vital Status ☐ Alive ☐ Dead
Cancer Status ☐ No Evidence ☐ Evidence ☐ Unk Status
Autopsy ☐ Yes ☐ No ☐ Unk if Autopsy
Place of Death _____

Recurrence
Recurrence Date _____
Recurrence Type
☐ In-situ ☐ Local ☐ Regional
☐ Distant ☐ Unknown
Describe _____

Comorbidities and Complications (ICD-10-CM)
1. _____
2. _____
3. _____
4. _____

Physicians (include surgeon, following physician, managing physician, etc)

Fax to Montana Central Tumor Registry, (406) 444-6557; for questions contact the MCTR at (406) 444-6786
This form can be found on https://dphhs.mt.gov/publichealth/Cancer/TumorRegistry