DERMATOLOGY CANCER REPORTING FORM

Form TR-003
Revised 05/2021

Reporting Physician and Address	Physician Phone	Date Form Completed	Date Received by MCTR
	Physician License or NPI #	Form Completed By	

PATIENT INFORMATION

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

Social Security Number | Date of Birth | Age | Referred From | 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

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

Telephone Number

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

Alcohol History: ☐ Yes ☐ No ☐ Previous ☐ Unk

Primary Payer | Usual Occupation | Usual Industry

CANCER INFORMATION

Date of Initial Diagnosis | Primary Site

Laterality: ☐ Not Paired ☐ Right ☐ Left ☐ Unk

Other Primary Tumors

Physical Findings (physical evaluation, x-ray, scans, scopes)

Pathology (Histology and Grade) (attach copies of all related pathology reports)

Size of Tumor

Lymph Node Involvement (include number of lymph nodes excised and number positive)

For Melanoma

Depth of Invasion (Breslow's) in mm: ________ Ulceration: ☐ Yes ☐ No VGP: ☐ Yes ☐ No

Clarks Level: ☐ I ☐ II ☐ III ☐ IV Mitotic Rate: ________ Regression: ☐ Yes ☐ No

Summary Staging

☐ In-situ ☐ Local ☐ Regional DE*

☐ Regional LN* ☐ Distant* ☐ Unknown

* Describe: ________

AJCC Staging

Clinical

T ________ N ________ M ________ Stage ________

Pathological

T ________ N ________ M ________ Stage ________

TREATMENT INFORMATION

Surgery (check all that apply and provide date)

☐ Shave Biopsy: Date ______ ☐ Wide Excision: Date ______

☐ Punch Biopsy: Date ______ ☐ Re-Excision: Date ______

☐ Excision/Excisional Biopsy: Date ______ ☐ Wide Re-Excision: Date ______

☐ MOHS: Date ______

Other Therapy
Describe any other non-surgical treatment given

____

Date Started

____

OUTCOMES

Status

Date of Last Contact or Death ________

Vital Status ☐ Alive ☐ Dead

Cancer Status ☐ No Evidence ☐ Evidence ☐ Unknown

Physicians

Surgeon ________

Following ________

Other ________

Please submit supporting text/documentation (e.g., pathology reports, radiology findings, pre-operative H&P, etc), to verify diagnosis, staging, histology, treatment, etc.

Please mail this form and documentation to the Montana Central Tumor Registry, PO Box 202952, 1400 Broadway, Room C-317, Helena, MT 59620.

Or fax the reports to (406) 444-6557. For questions, contact the MCTR at (406) 444-6786.