MONTANA CENTRAL TUMOR REGISTRY ABSTRACTING FORM

Form TR-003
Revised 8/10

Reporting Hospital	Abstracted By	Date Abstracted	Date Received by MCTR

PATIENT INFORMATION

Facility # | Accession # | Sequence # | Date First Contact | Medical Record Number

Name of Patient: Last | First | Middle | Maiden | Alias | Primary Payer

Physical Address: No & Street | City | County | State | Zip Code

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

Race | Hispanic Origin | Sex | Age | Marital Status | Name of Spouse/Parent | Place of Birth

Telephone Number | Tobacco History | Alcohol History

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

Place of Diagnosis (if diagnosed elsewhere, please describe place)

☐ This Hospital ☐ Other Hospital
☐ Physician's Office ☐ Unknown ☐ Other ______________________________

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.

Collaborative Staging

Tumor Size ________________ Describe Size ____

Extension ____

Regional Lymph Nodes *Positive* ____________ Regional Lymph Nodes *Examined* ____________

Sites of Distant Metastases ____

Substantiate 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 ☐ Unknown

Cause of Death ______________________________

Autopsy ☐ Yes ☐ No ☐ Unknown

Place of Death ______________________________

Recurrence

Recurrence Date ______________________

Recurrence Type

☐ In-situ ☐ Local ☐ Regional

☐ Distant ☐ Unknown

Describe ____________________________

Comorbidities and Complications (ICD-9-CM)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Physician – Surgeon | Physician – Follow-Up | Physician - Managing | Physician – 3 | Physician – 4

Fax to Montana Central Tumor Registry, (406) 444-6557