WEST VIRGINIA CANCER REGISTRY HOSPICE CANCER REPORT

Name and address of reporting facility

Name and address of diagnosing physician

Patient Last Name | First | MI | Suffix | Marital Status

Patient Physical Home Address (Do Not Use P.O Box)

City | State | Zip | County

Social Security Number | Sex | Race | Spanish/Hispanic | Date of Birth (MM/DD/YYYY)

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Date of Diagnosis (MM/DD/YYYY) | Primary Payer at Diagnosis | Number and Site of Previous Primary Cancers

Describe **primary site** and attach documentation | For paired sites, indicate **laterality**

Describe **cell type/histology** and attach copy of pathology report

Describe **tumor size** and attach relevant reports including reports documenting procedures done to diagnose and stage this cancer

Describe **extent of tumor** and attach relevant reports

Provide any information about **lymph nodes** (e.g., how many and which nodes were evaluated and how many were positive) and attach relevant reports

Provide any information about **metastases** (e.g., was there evidence of metastases and if so, to where) and attach relevant reports

Provide any information about **stage at diagnosis** (e.g., AJCC stage) and attach relevant documents

Provide date and description of **first course of treatment** or, if referred elsewhere for treatment, specify to where patient was referred

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Date of last contact or death (MM/DD/YYYY) | Is patient alive or dead?

Please attach all supporting documentation of initial diagnosis of Cancer.

Please submit report to:

West Virginia Division of Cancer Epidemiology
WVDHHR - Bureau for Public Health
350 Capitol Street, Room 125
Charleston, WV 25301
Phone: (304) 356-4953 Fax: (304) 558-4463

Document must be sent secure.

INSTRUCTIONS FOR COMPLETING HOSPICE CANCER REPORT FORM

PLEASE DO NOT LEAVE ITEMS BLANK. IF INFORMATION IS NOT AVAILABLE, PLEASE NOTE THAT.

PLEASE ATTACH ALL REQUESTED REPORTS. IF YOU HAVE QUESTIONS, PLEASE CALL (304) 356-4953.

Reporting facility: Name and address of reporting facility

Diagnosing physician: Name and address of physician making the diagnosis

Patient name: Patient's full name

Marital status: Patient's marital status

Patient address: Patient's home address at the time of diagnosis

Social Security Number: Patient's Social Security Number

Sex: Male, female or other (e.g., inter-sex; transgendered)

Race: American Indian or Alaska Native; Asian or Pacific Islander; Black; White (more than one race may be specified)

Spanish or Hispanic: A person is considered to be Spanish or Hispanic if their ethnic origin includes Mexican, Puerto Rican, Cuban, South or Central American (except Brazil), Dominican Republic, or other Spanish or Hispanic origins including European

Date of birth: Patient's date of birth

Date of diagnosis: Month, day and year this cancer was first diagnosed

Primary payer at diagnosis: Patient's primary payer/insurance carrier at time of diagnosis; includes: Not Insured; Not Insured – Self Pay; Insurance, NOS; Insurance – HMO, PPO or Managed Care; Insurance - Fee for Service; Medicaid; Medicaid Administered through Managed Care; Medicare without Supplement; Medicare with Supplement; Medicare Administered through Managed Care; Medicare with Private Supplement; Medicare with Medicaid Eligibility; TRICARE; Military; Veteran's Affairs; or Indian/Public Health Service

Number and site of previous primary cancers: Primary malignancies diagnosed before this one

Primary site: The anatomic site of the cancer

Laterality: The following primary sites have laterality and reporters should note whether the cancer arose in the left or right side or whether it is bilateral in origin or of unknown origin

Parotid , submandibular and sublingual glands	Pleura	Peripheral nerves and autonomic nervous system of upper limb and shoulder and lower limb and hip	Eye and lacrimal gland
Tonsillar fossa, tonsillar pillar, overlapping lesion of lonsil and tonsil, NOS	Long and short bones of upper limb and scapula	Connective, subcutaneous and other soft tissues of upper limb and shoulder and lower limb and hip	Cerebral meninges, NOS, cerebrum, fromtal lobe, temporal lobe, parietal lobe, occipital lobe
Nasal cavity (excluding nasal cartilage and nasal septum)	Long and short bones of lower limb	Breast	Olfactory nerve, optic nerve, acoustic nerve and cranial nerve, NOS
Middle ear	Rib and clavicle (excluding sternum)	Ovary and fallopian tube	Adrenal gland
Maxillary and frontal sinus	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)	Testis, epididymis and spermatic cord	Carotid body
Main bronchus (excluding carina) and lung	Skin of eyelid, external ear, other and unspecified parts of face, trunk, upper limb and shoulder, lower limb and hip	Kidney, NOS, renal pelvis and ureter	

Cell type or histology: Usually found in the pathology report and should be described as specified in that report, which should also be attached

Tumor size: Specify tumor size at diagnosis and unit of measurement (e.g., mm), or, if tumor size is described (e.g., microscopic focus; less than 2 mm; pea-sized) provide that description, attaching documentation

Extent of tumor: May include terms such as non-invasive or in situ, may specify depth of penetration through the primary site or may describe extension to contiguous structures. For information specific to the site you are reporting, please refer to the Collaborative Staging Manual, found at http://www.cancerstaging.org/cstage/manuals.html

Lymph nodes: Please include all information on regional lymph nodes here, including number examined and number positive. For information specific to the site you are reporting, please refer to the Collaborative Staging Manual, found at http://www.cancerstaging.org/cstage/manuals.html

Metastases: For information specific to the site you are reporting, please refer to the Collaborative Staging Manual, found at http://www.cancerstaging.org/cstage/manuals.html

Stage at diagnosis: Usually based on the American Joint Committee on Cancer Staging Manual (currently 6th edition); if available, provide T, N, and M as well as the stage group

First course of treatment: All treatment modalities (e.g., surgery, chemotherapy, radiation, biologic response modifier, hormone) included in the first course of treatment planned after diagnosis; be as specific as possible, including start dates, agents, etc. and attach documentation when possible

Date of last contact: Provide date your facility last had contact with patient or the date of death, if applicable

Alive or dead: If date of last contact was date of death, note that patient is dead