PRCCR Use Only

☐Y-CRS No._____☐UPDate_____

☐N-CRS ☐ F/UP Date_____☐Letter ☐Call

☐ NO INFO ☐Abstract ☐Hold Processed by_____

PUERTO RICO CENTRAL CANCER REGISTRY
HOSPICE REPORTING FORM

Patients admission date: _____
(MM/DD/YYYY)

Institution's Information

Name of institution: _____ Attending MD_____
(Within Institution)

Address_____Phone # (___) _____

Patient's Information

Patient's Name _____ Date of Birth _____
(Paternal & Maternal last names, Name, Middle name) (MM/DD/YYYY)

Social Security No. _____ MS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown Sex ☐ Male ☐ Female ☐ Other

Patient's Address _____ Phone # (___) _____
(Please select type of address) (Note: Please provide physical instead of postal address)

☐ Patient's home _____ ☐ Patient's home_____

☐ Relative _____ ☐ Relative _____

☐ Nursing home _____ ☐ Nursing home _____

Diagnosis Information

Organ/system where cancer is located _____Type of cancer_____
(For example: Colon, Breast, Prostate, Blood, Lymph nodes) (For example: Adenocarcinoma, Melanoma, Sarcoma, Brain tumor, Leukemia)

Additional information_____
(Evidence of treatment) ☐Surgery ☐ Chemotherapy ☐ Radiotherapy ☐ Other

Date FIRST DIAGNOSED _____ MD_____(outside institution)
(MM/DD/YYYY)
(If the exact date on which the diagnosis was made is not available, then record an approximate date. Do not leave blank)

Follow Up Information

Patient was transferred *from*: ☐ Patient's home ☐ Hospital ☐ Nursing home ☐ Other (Specify) _____

Name of Institution _____Physician: _____

Address _____ Phone # (_____)_____

_____

Patient was transferred *to* ☐ Patient's home ☐ Hospital ☐ Nursing home ☐ Other (Specify) _____

Name of Institution _____

Date of last contact with the patient _____ Vital Status ☐ Alive ☐ Dead
(MM/DD/YYYY)

Form completed by _____ Position_____
(Please PRINT)

Date _____
(MM/DD/YYYY)

PRCCR 016 – Hospice Reporting Form
Rev. 02/2019

Instructions for Hospice Reporting Form

Institution Information

- Name of institution: name of the reporting facility
- Attending physician: complete name of the physician in charge of the patient in your facility
- Address: institution address
- Phone: phone number of the reporting facility

Patient Information

- Patient's name: please provide the complete name of the patient (include both last names and middle name when available)
- Date of birth: please provide the patient's date of birth
- Social Security number: please provide the patient's social security number
- Marital Status (MS): please select the appropriate option
- Sex: please select the appropriate option
- Address: we provide writing space for up to two addresses. Please provide the patient's physical address (municipality, urbanization, barrio, sector) as detailed as possible.
- Phone: provide the phone number of the patient

Diagnosis Information

- Organ/system where the cancer is located: please specify where in the body the cancer is located. For example: Right Breast, Left Lung, Prostate, Ovary, Uterus, Blood, Lymph nodes, Pancreas, Liver.
- Type of cancer: please specify the type of cancer. Consult with the attending physician if needed. For example: Adenocarcinoma, Leukemia, Lymphoma, Brain tumor, Sarcoma, Multiple Myeloma, Melanoma.
- Additional information: please provide any information regarding treatment, for instances, surgery as mastectomy or colectomy, chemotherapy, radiotherapy or hormones.
- Date first diagnosed: please provide the date when the patient was FIRST diagnosed with the cancer. If no exact date is available then record an approximated date. DO NOT LEAVE BLANK.
- MD: provide the complete name of the physician in charge of the patient OUTSIDE your facility or the physician of the first diagnosis

Follow Up Information

- Patient was transferred from: select the appropriate option. Where is the patient coming from?
- Name of institution: provide the name of the institution, if applicable, where the patient is coming from.
- Address: provide the address of the institution where the patient is coming from
- Phone: provide the phone number of the institution where the patient is coming from
- Patient was transferred to: select the appropriate option. Where is the patient going to?
- Name of institution: provide the name of the institution, if applicable, where the patient is going to.
- Date of last contact with the patient: record the most recent date.
- Vital Status: select the appropriate option
- Form completed by: provide the name of the person filling this form
- Position: provide the position of the person filling the form, for example, registrar, supervisor, data clerk.
- Date: provide the date when the form was completed

PUERTO RICO CENTRAL CANCER REGISTRY
PMB 711 Ave. De Diego #89 Suite105 San Juan, PR 00927-6345 Phone: (787) 772-8300 ext. 1103 Fax: (787) 522-3283