REGISTRO CENTRAL DE CÁNCER DE PUERTO RICO

Puerto Rico Central Cancer Registry Physician's Reporting Form

PMB #711 Ave. De Diego #89 Suite 105 San Juan, PR 00927-6345

Patient ID #:_________________________

For PRCCR Use Only

PHYSICIAN

[1]Paternal Last Name	[2]Maternal Last Name	[3]First Name	[4]PR License #	[5]National Provider Identifier (NPI)

PATIENT

[6]Paternal Last Name	[7]Maternal Last Name	[8]First Name	[9]Middle Name	[10]Social Security Number (SSN)

[11]*Address line1* Number and Street	[12]*Address line2* Supplementary	[13]*Address line3* Municipality	[14]*Address line4* State	[15]*Address line5* Zip Code

[16]Date of Birth	[17]Sex	[18]Record Number	[19]Date of 1st visit	[20]Marital Status at Dx

[21]Father's Name	[22]Mother's Name	[23]Previous history of cancer?	[24]If *yes*, specify primaries	[25]Health Insurance

CANCER IDENTIFICATION

[26]Date of Initial Dx	[27]Age at Dx	[28]Cancer Primary Site	[29]Laterality

[30]Histology	[31]Behavior

[32]Grade	[33]Diagnostic Confirmation

[34]Summary Stage	[35]TNM					
	T		N		M	

[36]Tumor Markers/Labs. (CA 19.9, CEA, CGA, HPV, LDH, ER, PR, HER2, KRAS, AFP, hCG, PSA, etc.)	[37]Physical Examination Tests (DRE, CT Scan, X-Rays, Bone Scan, etc.)

TREATMENT

[38]*Surgery*	Date		Surgery type	
[39]*Radiation*	Date		Radiation type	
[40]*Chemotherapy*	Date		Chemotherapy type	
[41]*Hormone*	Date		Hormone type	
[42]*BRM*	Date		BRM type	
[43]*Active Surveillance/Other*	Date		Procedure (type)	
[44]LAST CONTACT	Date		Status	

[45]REFERRED TO

[46]COMMENTS *(if any)*

[47]COMPLETION

Person	
Date	