

MEMORIAL HOSPITAL - PATIENT IDENTIFICATION

Acsn # _____ / _____ / _____

Patient Last Name First Name MI Prefix Suffix

Maiden Name/Alias SocSec# MR #

Address _____ County _____

City/St _____ Zip + 4 _____ Area Code/Phone # _____ / _____ - _____

PT PERSONAL INFO Birthdate _____ / _____ / _____ Age _____ Birth Loc _____

Sex _____ Race _____ Hisp Orig _____ Race#2-5 _____ Insurance _____

Spouse Last Name/First Name _____

Occup _____ Indus _____

Comments _____

SECONDARY CONTACT Phone _____ - _____ Relation _____

Last Name First Name MI

Address _____

City _____ St _____ Zip+4 _____

DIAGNOSIS IDENTIFICATION Seq # _____

Site _____ Site code _____

Histology _____ Hist code _____

Behavior _____ Grade _____ Coding Sys Site **CCC** Morph **CCC** Conv flag **CCC**

Laterality _____ Dx Confirm _____ Rpt Src _____ Casef Src _____ Class/Case _____

Supporting Text _____

DATE INIT DX _____ / _____ / _____ Admit _____ / _____ / _____ D/C _____ / _____ / _____

DX EXT OF DIS CS Tumor Sz (mm) _____ **CS Extension** _____ CS T Eval _____

#LN exam _____ #LN + _____ **CS LN** _____ CS N Eval _____

CS Ver 1st _____ CS Ver Latest _____ **CS Mets** _____ CS M Eval _____

CS SS Factors #1 _____ **#2** _____ **#3** _____ **#4** _____ **#5** _____ **#6** _____
C38.4 only C619 only

Sum Stage _____ Version **CCC** Derived **CCC**

PT _____ N _____ M _____ Stage _____ Descrip _____ Staged By _____ **AJCC Ed** **CCC**

cT _____ N _____ M _____ Stage _____ Descrip _____ Staged By _____

Staging Descrip _____

Date First Course of Treatment _____ / _____ / _____ Date Init Rx _____ / _____ / _____

Surgery

Date _____ / _____ / _____ Surg Prim Site _____ Scope LN _____ Other _____ Reason No Surg _____

Date _____ / _____ / _____ Surg Prim Site _____ Scope LN _____ Other _____ Reason No Surg _____

Date _____ / _____ / _____ Surg Prim Site _____ Scope LN _____ Other _____ Reason No Surg _____

OTHER TREATMENT

Date _____ / _____ / _____ Radiation Sum _____ Surg/Rad Seq _____ Reg Rad Rx Modal _____

Date _____ / _____ / _____ Chemotherapy Sum _____

Date _____ / _____ / _____ Hormone Sum _____

Date _____ / _____ / _____ BRM Sum _____ Other Rx Sum _____ Transpl/Endocr Sum _____

PHYS SEQ

N = _____

M = _____ Ref From _____

R = _____ Add _____

F = _____ Ref To _____

2 = _____ Add _____

3 = _____ Comments: _____

PT STATUS

Date Last Contact _____ / _____ / _____ Vital Stat _____ CA Status _____ FU Source _____

COD (ICD) _____ ICD Revision _____

OVERRIDE FLAGS

Age/Site/Morph **CCC** SeqNo/Dx Conf **CCC** Site/Lat/SeqNo **CCC** Site/Type **CCC** Histol **CCC**

Rept Source **CCC** Ill-def Site **CCC** Leuk,Lymph **CCC** Site/Beh **CCC** Site/Lat/Morph **CCC**

Additional Data

Census Tract **CCC** Cen Cod Sys **CCC** Cen Year **CCC** Cen Tr Cert **CCC**

NHIA Hisp Orig **CCC** IHS link **CCC** Comp Ethn **CCC** Comp Ethn Src **CCC**

Rec Type **CCC** Unique Pt ID **CCC** Reg ID **CCC** NAACCR Rec Ver **CCC**

KEY Data items in **Bold** are required fields Other data items are optional or "advanced surveillance"
ccc computed field, no manual input **Shaded** are optional non-NPCR items