Confidential Fax Transmittal
Physician Cancer Reporting Form

To:	From:
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PATIENT	
Last Name*	
First Name*	
Middle Name	
Birth Date*	
SSN	
Medical Record Number*	
Spanish/Hispanic Origin*	
Race*	
Sex*	
Insurance Payer	
Longest Held Occupation	
Date Last Contact	

PATIENT ADDRESS	
Street*	
City*	
State*	
Zip*	

ATTENDING PHYSICIAN DETAILS	
Last Name*	
First Name*	
Middle Name	
NPI Number*	
CA License Number*	
Email*	
Physician Street*	
Physician City*	
Physician State*	
Physician Zip*	

DIAGNOSIS	
Date of Diagnosis*	
Diagnostic Confirmation	
Primary Site*	
Histology Behavior*	
Laterality*	
Grade	
Clinical Stage Group	
Clinical T	
Clinical N	
Clinical M	
Path Stage Group	
Path T	
Path N	
Path M	
Tumor Size (millimeters)	

TREATMENT (WITH SURGERY)	
Surgical Facility	
Surgical Date	
Surgical Treatment	

TREATMENT (WITH RADIATION)	
Radiation Therapy	
Radiation Start Date	
Radiation Procedure	

TREATMENT (WITH DRUGS)	
Drug Agents	
Drug Start Date	
Drug Treatment Narrative	

COMMENT(S):

The * next to the fields above denote the information required for meeting your cancer reporting requirements. The remaining fields are requested if available.