Confidential Fax Transmittal Physician Cancer Reporting Form

TO:	ATTENTION:	FAX:
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Required Information: The (*) next to the fields below denote the information required for meeting your cancer reporting requirements. The remaining fields are required if available and enhance the completeness of the physician reported data.

Patient

FIRST NAME*	MIDDLE NAME	LAST NAME*
BIRTH DATE*	SOCIAL SECURITY NUMBER (SSN)	MEDICAL RECORD NUMBER*
SPANISH/HISPANIC ORIGIN ☐ Yes ☐ No	RACE	SEX*
INSURANCE PAYER		
LONGEST HELD OCCUPATION		DATE LAST CONTACT

Patient Address

STREET*		
CITY*	STATE*	ZIP CODE*

Attending Physician Details

FIRST NAME*	MIDDLE NAME	LAST NAME*
BIRTH DATE*	NPI NUMBER*	CALIFORNIA LICENSE NUMBER*
EMAIL*		
STREET*		
CITY*	STATE*	ZIP CODE*

Diagnosis

DATE OF DIAGNOSIS*	DIAGNOSTIC CONFIRMATION*
PRIMARY SITE*	HISTOLOGY BEHAVIOR*
LATERALITY*	
AJCC CLINICAL TNM	AJCC PATHOLOGIC TNM

Surgery

SURGICAL FACILITY	SURGICAL DATE
SURGICAL TREATMENT	TUMOR SIZE

Radiation

RADIATION THERAPY*	RADIATION START DATE
RADIATION PROCEDURE	

Drugs

DRUG AGENTS	DRUG START DATE
DRUG TREATMENT NARRATIVE	

Comment(s)

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