GUAM CANCER REGISTRY REPORT FORM

RESET FORM

Physician Name: _____

Address: _____

Contact Number: _____

Patient Name: _____ Date of Birth: _____ Sex: _____ SS#: _____

Residential Address at Diagnosis: _____ Marital Status: _____

_____ _____ ☐ Yes ☐ No

Occupation (If retired, indicate recent occupation), Industry Race/Ethnicity Served in US Armed Forces

MUST ATTACH DOCUMENTS TO SUPPORT INFORMATION BELOW (DIAGNOSTIC & TREATMENT REPORTS/SUMMARIES)

Primary Site/Laterality: _____ Histology Type: _____

Date this cancer was **FIRST DIAGNOSED**: _____

Most recent visit for this cancer: _____

Method of Diagnosis

- ☐ Positive histology
- ☐ Positive cytology
- ☐ Autopsy
- ☐ Radiography
- ☐ Clinical
- ☐ Positive lab test marker study

Patient Status

- ☐ Alive, free of cancer
- ☐ Alive, evidence of cancer
- ☐ Alive, cancer status unknown
- ☐ Deceased, free of cancer
- ☐ Deceased, evidence of cancer
- ☐ Deceased, cancer status unknown

Did this patient receive any treatment for this cancer? ☐ Yes ☐ No ☐ Unknown

If "Yes", please complete the following:

Treatment	**Date**
Surgery (type):	
Radiation (type, duration):	
Chemotherapy (specify agents, duration):	
Hormone/Other treatment (type, duration):	

Referred to Physician/Hospital:

Name: _____

Address: _____

Tel/Fax Number: _____

Please Return Completed Form To: **Guam Cancer Registry, Cancer Research Center Guam Dean's Circle House #27, UOG Station, Mangilao, GU 96923**

Fax: (671)734-2990 Phone: (671)735-2988/0129