

# GUAM CANCER REGISTRY REPORT FORM

Physician Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Last, First, Middle Name)      Date of Birth      Sex      Social Security Number

\_\_\_\_\_  
Residential Patient Address at Diagnosis      Marital Status

\_\_\_\_\_  
Occupation (Do not write "Retired")      Industry      Race/Ethnicity      Ever Served in USA Armed Forces?  
 Yes       No

\_\_\_\_\_  
Primary Site/Laterality of this cancer (attach pathology report):

\_\_\_\_\_  
Histology Type of this cancer:

\_\_\_\_\_  
Date this cancer was FIRST DIAGNOSED:      /      /  
Month/Day/Year

\_\_\_\_\_  
Initial visit for this cancer:      /      /      Most recent visit for this cancer:      /      /  
Month/Day/Year      Month/Day/Year

## METHOD OF DIAGNOSIS

- Positive histology
- Positive cytology
- Autopsy
- Radiography
- Clinical
- Positive lab test marker study
- Method Unknown

## 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

If "Yes", please complete the following:

\_\_\_\_\_  
Surgery (specify type)      /      /      /  
Month      Day      Year

\_\_\_\_\_  
Radiation (specify type, duration)      /      /      /  
Month      Day      Year

\_\_\_\_\_  
Chemotherapy (specify agents, duration)      /      /      /  
Month      Day      Year

\_\_\_\_\_  
Hormone/Other Treatment (specify type, duration)      /      /      /  
Month      Day      Year

\_\_\_\_\_  
Referred to Physician/Hospital:      Name

\_\_\_\_\_  
Address      Tel / Fax Number

Please Return Completed Form To: **Guam Cancer Registry, Cancer Research Center Guam**  
**Dean Circle House #7, UOG Station, Mangilao, Guam 96923**  
**Fax: (671) 734-2990**