Washington State Department of Health
DOH 140-195 January 2019

CANCER REPORTING FORM
Washington State Cancer Registry
January 2019

CASE IDENTIFICATION

Last Name | First Name | MI | Birthdate: | Social Security Number: | Sex ☐ M ☐F

Physical Street Address: | City: | State | Zip Code | Home Phone

Usual Occupation | Industry

Race
☐ African American ☐ Asian
☐ American Indian ☐ White
☐ Pacific Islander ☐ Unknown

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Primary Insurance

CANCER DATA (Diagnostic Information)

Date of Diagnosis | Primary Site

Histology and Grade

STAGE OF DISEASE

☐ In Situ
☐ Localized
☐ Regional, direct extension
☐ Regional, nodes
☐ Distant
☐ Unknown

OR

TNM STAGING

T
N
M

PRACTITIONER IDENTIFICATION

Telephone: ( ) | Fax: ( )

Practitioner Name | NPI #

Address:

City | State | Zip Code

Patient referred to:

Person completing the form and date completed:

Please mail or fax this form, along with a pathology report (if available) to:

Washington State Cancer Registry
310 Israel Rd
PO Box 47855
Tumwater, WA 98504-7855

Tel: 360-236-3618
Fax: 360-586-2714

Please include a copy of all pathology reports related to the patient's diagnosis, including re-excisions with no evidence of residual malignancy.

CANCER DIRECTED TREATMENT

Biopsy:
Physician: Dr Kid
Biopsy Type: _____
Date: _____
Facility Name: _____

Surgery: Yes ☐ No ☐
Date: _____
Type: _____
Facility Name: _____

Chemotherapy: Yes ☐ No ☐
Date Started: _____
Agents: _____
Facility name: _____

Radiation Therapy: Yes ☐ No ☐
Date Started _____
Type: _____
Facility name: _____

Hormone Therapy: Yes ☐ No ☐
Date Started: _____
Type: _____
Facility Name: _____

Other: (Please Explain) _____
_____

PATIENT STATUS

Alive/Deceased: _____
Date of Last Contact: _____

Status of Tumor:
Evidence: ☐ No Evidence ☐ Unk ☐

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).