New Jersey Department of Health and Senior Services
Cancer Epidemiology Services
PO Box 369, Trenton, NJ 08625-0369
Phone: (609) 588-3500 Fax: (609) 588-3638

FOR OFFICE USE ONLY

CTR Number: _____

HCF Code: _____

PHYSICIAN REPORT FORM (09700)

Physician Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Patient Name | **Date of Birth** | **Social Security Number**

Patient Address | **Race/Ethnicity** | **Marital Status** | **Sex**

City, State, Zip Code | **Occupation** | **Industry**

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: ____/____/____
Month/Day/Year

Most recent visit for this cancer: ____/____/____ ☐ **Alive** ☐ **Dead**
Month/Day/Year

STAGE INFORMATION *(Please refer to AJCC Cancer Staging Manual, 6th Edition)*

Primary Tumor (T) _____ **Regional Lymph Nodes(N)** _____ **Direct Metastasis (M)** _____ **Stage Group** _____

Tumor Size: _____
For malignant melanomas, record size, depth and thickness

Tumor Markers: _____ _____
Name *Results*

LDH Results _____ **Clinical Lymph Node Status @ Dx:** _____

Did this patient receive any treatment for this cancer? ☐**Yes** ☐ **No** **If "Yes," please complete the following:**

Surgery *(specify type)* *(margin status)* ____/____/____ **Month Day Year**

Radiation *(specify agents, duration, 1st course or subsequent)* ____/____/____ **Month Day Year**

Chemotherapy *(specify agents, duration, 1st course or subsequent)* ____/____/____ **Month Day Year**

Hormone *(specify type, duration)* ____/____/____ **Month Day Year**

Immunotherapy/Other Treatment *(specify type, duration)* ____/____/____ **Month Day Year**

Referred to Physician/Hospital:

Provider Name | *Address, Suite, City, Zip* | *Phone Number*

USE BACK OF FORM FOR ADDITIONAL COMMENTS