

**FOR OFFICE USE ONLY**

CTR #: \_\_\_\_\_

DTR: \_\_\_\_\_

DA: \_\_\_\_\_

**HEMATOLOGY/ONCOLOGY PHYSICIAN REPORT (09700)**

Practice Name: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, Zip Code: \_\_\_\_\_  
 Telephone / Fax: \_\_\_\_\_

_____ 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:     /    /      
Month/Day/Year

**STAGE INFORMATION**

Primary Tumor (T) \_\_\_\_\_ Regional Lymph Nodes(N) \_\_\_\_\_ Distant Metastases (M) \_\_\_\_\_

Tumor Size: \_\_\_\_\_ Systemic Symptoms at Dx: \_\_\_\_\_ IPI Score \_\_\_\_\_

Stage @ Diagnosis: \_\_\_\_\_ Lymph Node Status @ Dx: \_\_\_\_\_

Tumor Markers: \_\_\_\_\_  
Name Results

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

_____ Surgery ( <i>specify type</i> )	_____ Month	_____ Day	_____ Year
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_____ Chemotherapy ( <i>specify agents, amount, duration</i> )	_____ Month	_____ Day	_____ Year
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_____ Radiation Therapy ( <i>specify amount, method, duration</i> )	_____ Month	_____ Day	_____ Year
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_____ Immunotherapy ( <i>specify type, duration</i> )	_____ Month	_____ Day	_____ Year
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_____ Hematologic Transplant and Endocrine Procedures	_____ Month	_____ Day	_____ Year
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_____ Hormone/Other Treatment ( <i>specify type, amount, duration</i> )	_____ Month	_____ Day	_____ Year
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Referred to Physician/Hospital:

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Address, Suite, City, Zip

\_\_\_\_\_  
Telephone

Date Completed:     /    /      
Month/Day/Year

Fax  Mail