New Jersey Department of Health
Cancer Epidemiology Services
PO Box 369, Trenton, NJ 08625-0369
Phone: (609) 633-0500 Fax: (609) 633-7509

FOR OFFICE USE ONLY

CTR Number: ________________

PHYSICIAN REPORT FORM (NON-HOSPITAL SOURCE) (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: / / (Month/Day/Year) ☐ **Alive** ☐ **Dead**

STAGE INFORMATION *(Please refer to AJCC Cancer Staging Manual.)*

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:**

Active Surveillance/watchful waiting? ☐**Yes** ☐ **No**

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*

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USE BACK OF FORM FOR ADDITIONAL COMMENTS