

FOR OFFICE USE ONLY
CTR Number: _____
HCF Code: _____

NON-HOSPITAL SOURCE REPORT FORM

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, 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