

New Jersey Department of Health and Senior Services
New Jersey State Cancer Registry
P.O. Box 369
Trenton, NJ 08625-0369
Telephone Number (609) 588-3500 / Fax Number (609) 588-3638

CANCER REGISTRY SURVEY

- Ambulatory Surgery Center Private Physician Office
 Hematological/Oncology Services Radiation Oncology
 Physician/Surgical Suite Services Other _____

1) Name of Practice/Physician _____

2) Address _____

3) E-Mail _____

4) Phone Number () _____ 5) Fax Number () _____

6) Name of Administrator _____

7) Name of Contact Person _____

8) Please check all cancer-related services provided by your practice below:

- Microscopic Diagnosis Immunotherapy (BRM)
 Clinical Diagnosis Allogeneic Bone Marrow Transplant
 Surgery Autologous Stem Cell Rescue
 Chemotherapy Therapy Interferons
 Hormonal Therapy Interleukins
 Radiation Therapy Stem Cell Transplant
 Palliative /Supportive Care Other _____

9) Record the number of cancer cases diagnosed and/or treated per year. (Exclude basal and squamous cell carcinoma of the skin)

2008: _____ 2009: _____ 2010 (Est.): _____

If your facility does not provide cancer-related services, do not proceed. Sign and return the survey to the above address.

Authorized Signature	Date
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**CANCER REGISTRY SURVEY
(Continued)**

Name of Practice/Physician _____

10) Current Operations

Do you currently report your cases to the NJSCR? Yes No
 Reporting Method _____ Frequency _____
 Responsible Person/Title _____
 Case Identification Method _____

Type of Operating System?
 Windows 98 Windows NT Windows ME
 Windows XP Windows 2000 Other _____

Please list your current software: _____

What type of reports can you generate?
 Procedure Report Yes No
 Diagnosis Report Yes No
 Registration Report Yes No
 Other _____

Is your billing system computerized? Yes No
 If so, do you bill using ICD-9 codes? Yes No
 Are you able to output HL7 data? Yes No

11) Would you like to report by electronic means to the NJSCR? Yes No

Name of Contact Person: _____

E-Mail: _____

Phone Number: _____ () Fax Number: _____ ()

Date Completed: _____

12) Does your facility receive copies of pathology reports from all labs? Yes No

Record the names and addresses of all laboratories where specimens are sent for diagnosis.

FOR STATE USE ONLY:	DTR:	DR:	DC:	DI:
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**CANCER REGISTRY SURVEY
(Continued)**

Name of Practice/Physician _____

13) Do you keep a medical record for each patient treated at your facility? If yes, please answer the following:

<u>Summary</u>	YES	NO
History and Physical.....	<input type="checkbox"/>	<input type="checkbox"/>
Operative Notes	<input type="checkbox"/>	<input type="checkbox"/>
Pathology Report(s)	<input type="checkbox"/>	<input type="checkbox"/>
 <u>Demographic Data</u>		
Patient Name	<input type="checkbox"/>	<input type="checkbox"/>
Maiden Name.....	<input type="checkbox"/>	<input type="checkbox"/>
Social Security Number	<input type="checkbox"/>	<input type="checkbox"/>
Full Address	<input type="checkbox"/>	<input type="checkbox"/>
Race.....	<input type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/>	<input type="checkbox"/>
Date of Birth/ Age.....	<input type="checkbox"/>	<input type="checkbox"/>
 <u>Cancer Identification</u>		
Date of Diagnosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Primary Site.....	<input type="checkbox"/>	<input type="checkbox"/>
Laterality.....	<input type="checkbox"/>	<input type="checkbox"/>
Histology/ Behavior	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Confirmation	<input type="checkbox"/>	<input type="checkbox"/>
 <u>Treatment Information</u>		
Date of first Contact	<input type="checkbox"/>	<input type="checkbox"/>
Type and Date of Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Type and Date of Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Type and Date of Hormone Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Type and Date of Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Type and Date of BRM Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Type and Date of Other Therapy	<input type="checkbox"/>	<input type="checkbox"/>
 <u>Stage/ Prognostic Factors</u>		
General Summary Stage.....	<input type="checkbox"/>	<input type="checkbox"/>
TNM Summary Stage.....	<input type="checkbox"/>	<input type="checkbox"/>
Collaborative Stage.....	<input type="checkbox"/>	<input type="checkbox"/>
 <u>Follow- up</u>		
Date Last Seen	<input type="checkbox"/>	<input type="checkbox"/>
Referring Physician	<input type="checkbox"/>	<input type="checkbox"/>
Physician Referred To.....	<input type="checkbox"/>	<input type="checkbox"/>

Comments:
