

**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  
ROCKY MOUNTAIN CANCER DATA SOFTWARE (RMCDs)  
INFORMATION REQUEST**

*NJSCR checklist was designed to gather information about an office practice under consideration for Rocky Mountain Cancer Data Software (RMCDs) installation. The following information requested will update our current records.*

- |   |   |
|---|---|
| <input type="checkbox"/> Ambulatory Surgery Center        | <input type="checkbox"/> Physician /Surgical Suite Services |
| <input type="checkbox"/> Hematological/ Oncology Services | <input type="checkbox"/> Radiation Oncology                 |
| <input type="checkbox"/> Private Physician Office         | <input type="checkbox"/> Other _____                        |

1) Name of Practice/Physician \_\_\_\_\_

2) Address \_\_\_\_\_

3) E-Mail \_\_\_\_\_

4) Phone Number (     ) \_\_\_\_\_

5) Fax Number (     ) \_\_\_\_\_

6) Name of Administrator \_\_\_\_\_

7) Administrator Phone Number (     ) \_\_\_\_\_

8) Name of Contact Person \_\_\_\_\_

9) Phone Number (     ) \_\_\_\_\_

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

- |  |  |
|--|--|
| <input type="checkbox"/> Microscopic Diagnosis       | <input type="checkbox"/> Immunotherapy (BRM)               |
| <input type="checkbox"/> Clinical Diagnosis          | <input type="checkbox"/> Allogeneic Bone Marrow Transplant |
| <input type="checkbox"/> Surgery                     | <input type="checkbox"/> Autologous Stem Cell Rescue       |
| <input type="checkbox"/> Chemotherapy Therapy        | <input type="checkbox"/> Interferons                       |
| <input type="checkbox"/> Hormonal Therapy            | <input type="checkbox"/> Interleukins                      |
| <input type="checkbox"/> Radiation Therapy           | <input type="checkbox"/> Stem Cell Transplant              |
| <input type="checkbox"/> Palliative /Supportive Care | <input type="checkbox"/> Other _____                       |

**11) Current Operations**

Do you currently report your cases to the NJSCR?    Yes            No

If yes, your current reporting method?    Monthly            Quarterly

Name and Title of Responsible Person: \_\_\_\_\_

What type of reports can you produce to identify potential reportable cases?

- |  |   |
|--|---|
| <input type="checkbox"/> Diagnostic Report | <input type="checkbox"/> Patient Registration |
| <input type="checkbox"/> ICD-9 Codes       | <input type="checkbox"/> Disease Index        |
| <input type="checkbox"/> CPT Codes         | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Billing Report    |   |

12) Yearly cancer caseload:    2008 \_\_\_\_\_           2009 \_\_\_\_\_           2010 (Est.) \_\_\_\_\_

**ROCKY MOUNTAIN CANCER DATA SOFTWARE (RMCDs)  
INFORMATION REQUEST  
(Continued)**

Name of Practice/Physician	Date Completed
----------------------------	----------------

13) Please attach the names and addresses of all laboratories to which specimens are sent for diagnosis.

*If you are interested in reporting electronically, please complete the following information. RMCDs software can be run on a single-user machine or on a network. Reportable cases are transmitted directly to the NJSCR via encrypted e-mail to a secure server. Implementation of RMCDs will require a CD ROM, basic hardware and software. Please note: Windows Vista is not recommended at this time. Please complete the following.*

- Operating System:** Windows XP, Windows Server 2003, Novell Server
- Machine Speed:** 1.3 GHz or Greater
- Memory:** 1 GB (Recommend: 2 GB)
- Disk Space for Registry:** 2 GB
- Monitor:** 17" Monitor or larger recommended
- Screen Resolution:** Minimum 800x600
- Required:** CD ROM
- Required:** Internet access with download capabilities
- Recommended:** Printer - Laser or Inkjet either attached or accessible through a network

14) Do you have the above requirements?

Yes       No

15) Administrative Rights

**Your Information Technology (IT) person should be present during the installation of the RMCDs CD. Administrative rights to install, update, edit, save, and delete data are necessary for a successful installation.**

Will installation be to a network or single unit?       Network       Single

How many users will enter data into the RMCDs?       1-2       3-4

Provide user name, initials, and password:

User 1 _____	<input type="text"/> <input type="text"/> <input type="text"/>	PW _____
User 2 _____	<input type="text"/> <input type="text"/> <input type="text"/>	PW _____
User 3 _____	<input type="text"/> <input type="text"/> <input type="text"/>	PW _____
User 4 _____	<input type="text"/> <input type="text"/> <input type="text"/>	PW _____

**Name of Information Technology (IT) Contact:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ (      )      **Fax Number:** \_\_\_\_\_ (      )

<b>FOR STATE USE ONLY:</b>	DTR: _____	DR: _____	DC: _____	DI: _____
----------------------------	------------	-----------	-----------	-----------

**ROCKY MOUNTAIN CANCER DATA SOFTWARE (RMCDs)  
INFORMATION REQUEST  
(Continued)**

Name of Practice/Physician	Date Completed
----------------------------	----------------

16) *The following data elements collected by the New Jersey Cancer Registry are available for entry into RMCDs database. Instructions on how to transmit cases electronically will be provided after installation and data entry. Please indicate which data items are available in your records.*

<u>Demographic Data</u>	YES	NO
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"/>
 <b><u>Cancer Identification</u></b>		
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"/>
 <b><u>Treatment Information</u></b>		
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"/>
 <b><u>Stage/ Prognostic Factors</u></b>		
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"/>
 <b><u>Follow-up</u></b>		
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:**

---



---



---



---



---

*Please return your completed checklist to the NJSCR via fax to (609) 588-3638.*