

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

HEMATOLOGY/ONCOLOGY INFORMATION REQUEST

1) Name of Practice/Physician _____

2) Address _____

3) E-Mail _____

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

6) Name of Administrator _____

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

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

8) Current Operations

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

If Yes, your current reporting method? Fax Mail

Frequency? Monthly Quarterly

Who is responsible for reporting your cases? _____

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 | |

9) Average annual cancer caseload:

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

10) Do you perform your own diagnostic procedures? Yes No

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

**HEMATOLOGY/ONCOLOGY INFORMATION REQUEST
(Continued)**

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If you are interested in receiving free Rocky Mountain Cancer Data Systems Software to report electronically, 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

12) Do you have the above requirements?

Yes No

13) 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?	<input type="checkbox"/> Network	<input type="checkbox"/> Single
How many users will enter data into the RMCDS?	<input type="checkbox"/> 1-2	<input type="checkbox"/> 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:** ____ (____) _____

Date Completed: _____

FOR STATE USE ONLY:	DTR:	DR:	DC:	DI:
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**HEMATOLOGY/ONCOLOGY INFORMATION REQUEST
(Continued)**

Name of Practice/Physician _____

14) Patient Information

The following data elements collected by the New Jersey Cancer Registry are available for entry into RMCDS database. 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"/>
<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:

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