

**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) Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

3) Phone Number ( ) \_\_\_\_\_ 4) Fax Number ( ) \_\_\_\_\_

5) Name of Administrator \_\_\_\_\_

6) E-Mail \_\_\_\_\_ 7) Phone Number ( ) \_\_\_\_\_

**8) 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 |

**9) Current Operations**

- Do you currently report your cases to the NJSCR?  Yes  No
- If Yes, your current reporting method?  Mail  Fax  Electronic
- 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    |   |

**10) Average annual cancer caseload:**

2010: \_\_\_\_\_ 2011: \_\_\_\_\_ 2012 (Est.): \_\_\_\_\_

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

12) Do you have a laboratory or a lab satellite at this location?  Yes  No

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Name of Practice/Physician \_\_\_\_\_

***If you are interested in receiving free Rocky Mountain Cancer Data Systems Software to report electronically, please complete the following:***

14) Do you have the following requirements?	Yes	No
<b>Operating System:</b> Windows 7, Windows XP, Windows Server 2003, Novell Server.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Machine Speed:</b> 1.3 GHz or Greater .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Memory:</b> 1 GB (Recommend: 2 GB) .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Disk Space for Registry:</b> 2 GB .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Monitor:</b> 17" Monitor or larger recommended .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Screen Resolution:</b> Minimum 800x600 .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Required:</b> CD ROM.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Required:</b> Internet access with download capabilities.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Recommended:</b> Printer - Laser or Inkjet either attached or accessible through a network .....	<input type="checkbox"/>	<input type="checkbox"/>

**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?	<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 _____	[ ][ ]	PW _____
User 2 _____	[ ][ ]	PW _____
User 3 _____	[ ][ ]	PW _____
User 4 _____	[ ][ ]	PW _____

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

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

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

**Date Completed:** \_\_\_\_\_

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

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

Name of Practice/Physician \_\_\_\_\_

---

---

**16) 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:

<b><u>Demographic Data</u></b>	<b>YES</b>	<b>NO</b>
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.*