PHYSICIAN REPORT FORM

State Health Registry of Iowa
2600 University Capitol Centre
The University of Iowa
Iowa City, IA 52242-5500

DEATH CERTIFICATE INFORMATION

Patient Name (last, first/middle) _____ Date of Birth _____ Record ID _____

Patient Residence _____ DC Number _____

Date of Death _____ Place of Death _____

PRIMARY SITE of this cancer: _____ HISTOLOGIC TYPE of this cancer: _____

PLEASE GIVE AS MUCH INFORMATION AS POSSIBLE

Date you FIRST SAW PATIENT for this cancer: _____ Month _____ Day _____ Year

Date this cancer was FIRST DIAGNOSED _____ Month _____ Day _____ Year

Was this patient an Iowa resident at diagnosis? ( ) Yes ( ) No

Stage at diagnosis: _____

Was patient hospitalized for this cancer? ( ) Yes ( ) No

If "yes", Name of Hospital & City _____ Month Day Year

Not my patient: _____ Contact: _____

METHOD OF DIAGNOSIS FOR THIS CANCER
Microscopically Confirmed:
( ) Autopsy
( ) Tissue from Primary Site
( ) Tissue NOT from Primary Site
( ) Cytology or Hematology
( ) Tissue Source or Method Unknown
NOT Microscopically Confirmed:
( ) Gross Specimen Only
( ) X-Ray Only
( ) Clinical
( ) Other _____
( ) Unknown

SPECIFY PRIMARY SITE, HISTOLOGY & LATERALITY:

_____

_____

ADDITIONAL COMMENTS:

_____

_____

_____

TREATMENT FOR THIS CANCER

Surgery: _____

_____ Place Month Day Year

Radiation Therapy:
( ) Cobalt ( ) Radium/Radon
( ) Linear Acc ( ) Type Unknown
( ) None or Unknown

_____ Place Month Day Year

Chemotherapy: _____

_____ Place Month Day Year

Other Therapy: _____

_____ Place Month Day Year

No Treatment: _____

Reason why: _____