



State Health Registry of Iowa

2600 University Capitol Centre, The University of Iowa, Iowa City, Iowa 52242-5500, PH: 319/335-8609, FAX: 319/335-8610

Demographics:

Patient First Name: _____ Middle: _____ Last: _____

Date of Birth: ___ \ ___ \ ___ SSN: ___ - ___ - ___ Sex: Male: ___ Female: ___

Race: Caucasian: ___ African American ___ Native American: ___ Other: _____

Ethnicity: Hispanic/Spanish? Yes ___ No ___ Unknown ___

Marital Status: Single: ___ Married: ___ Divorced: ___ Widowed: ___ Unknown: ___

Insurance Provider: _____

Patient Address: Street: _____ City: _____ State: ___ Zip: _____

Date of Diagnosis: ___ \ ___ \ ___ Physician who diagnosed the cancer: _____

Site: _____ Histology: _____ Laterality: Right: ___ Left: ___ Midline: ___ Unknown: ___

Extent of Disease/Stage:

Tumor Size: _____ Direct Extension: _____ Metastasis: _____

Was there lymph node involvement? Yes: ___ No: ___ Unknown: ___

Local Nodes? _____ Regional? _____ Distant? _____

METHOD OF DIAGNOSIS FOR THIS CANCER	
Check all that apply:	
Microscopically Confirmed:	
<input type="checkbox"/>	Autopsy
<input type="checkbox"/>	Tissue
<input type="checkbox"/>	Cytology or Hematology
NOT Microscopically Confirmed:	
<input type="checkbox"/>	Observation
<input type="checkbox"/>	X-Ray/Scan
<input type="checkbox"/>	Clinical
Unknown:	

TREATMENT FOR THIS CANCER	
Surgery:	
<input type="checkbox"/> Facility:	Date: / /
Radiation:	
___ Beam ___ Radiation Implants ___ Radioisotope ___ Refused ___ None or Unknown	
<input type="checkbox"/> Facility:	Date: / /
Chemotherapy:	
<input type="checkbox"/> Facility:	Date: / /
Other:	
<input type="checkbox"/> Facility:	Date: / /

No treatment was given, reason: _____

Does this patient have a history of previous cancer? No ___ Yes ___, Site _____ Histology: _____

Date of Diagnosis ___ / ___ / ___

Patient Status: Alive ___ Last known date ___ \ ___ \ ___

Deceased ___ Date of death ___ \ ___ \ ___

Unknown/No information _____

Physician completing form: _____ Date: ___ \ ___ \ ___ Phone: (___) ___ - ___

Please FAX the completed form and **all pertinent pathology and/or autopsy reports** to the State Health Registry of Iowa Attention: Bobbi Jo Matt. **Fax # (319) 335-8610**

Or Express Mail to: State Health Registry of Iowa, 201 S Clinton, University Capitol Centre (UCC) Suite 2600, Iowa City, IA 52240-4034. Attention: Bobbi Jo Matt

With special arrangements a secure data file transfer site can be made available

If you have any questions please call Bobbi Jo Matt at **(319) 335-8325**.