Virgin Islands Central Cancer Registry – Hospice Cancer Report Form*

Charles Harwood Complex, 3500 Estate Richmond
Christiansted, VI 00820-4370
Tel. (340) 718-1311 x 3774, 3793, 3700 / Fax (340) 718-9505 / Email: viccr@doh.vi.gov

Hospice Care Facility Information		
Physician Name	Facility Name	Referred to:

Patient's Information			
Full Name (First, Middle and Last)	Social Security		Sex: ☐ Male ☐ Female ☐ Other: ___________________
Physical Address (please include Estate, City, State, Zip)			Phone Number
Medical Record #	Date and Place of Birth	Marital Status	Health Insurance
Race: ☐ Caucasian / White ☐ Black ☐ Asian ☐ Native American ☐ Other ☐ Unknown ****For Hispanic patients, please select a race.*			Hispanic: ☐ Yes ☐ No ☐ Other

Cancer Information		
Date of Diagnosis	Primary Site (e.g.: colon, breast, prostate, etc.)	Histology (adenocarcinoma, squamous carcinoma, lymphoma)
Place of diagnosis		

Diagnostic Work Up at Diagnosis
Physical examination
X-Ray / Scans / Scopes

Treatment Information			
	Type / Description	Date	Where performed
Surgery			
Radiation			
Chemotherapy			
Hormone			
BRM			
Other (includes alternative medicine)			

Additional Comments

Follow Up / Patient Status	**Completed by**
Date of last contact: Vital Status: ☐ Alive ☐ Dead Cancer Status: ☐ evidence of CA ☐ no evidence of CA If expired; please provide date and place of death:	Name: Date:

***This form is intended for hospice care setting ONLY. Not for physicians, hospitals or healthcare clinics.**
****Please, send the completed form to the VICCR via e-mail to: viccr@doh.vi.gov**
To protect our patient's privacy and to comply with HIPAA regulations the attached forms must be encrypted and password protected using an encryption software. Microsoft encryption is not recommended.

HOSPICE'S CANCER REPORT FORM INSTRUCTIONS

Facility Information	
Reporting Facility Section	Record the complete name, address, and telephone number of your facility or physician's office.

Patient Information	
Name	Record the patient's full name.
Social Security Number	Record the patient's social security number. Do not record a spouse's number.
Sex	Check off the patient's sex/gender.
Physical Address	Record patient's permanent home address at time of diagnosis, not a temporary relocation for treatment. Street address takes priority over post office box number.
Phone Number	Record the patient's phone number
Medical Record Number	Record the patient's medical record number
Date and Place of Birth	Record patient's birth date in MM/DD/YYYY format. Also record the place of birth.
Marital status	Specify patient's marital status at time of diagnosis
Health Insurance	Record the patient's health insurance
Race	Check off the patient's race.
Hispanic Origin	Check off whether the patient considers himself or herself to be of Hispanic origin.

Cancer Information	
Date of Diagnosis	Record the date the patient was first diagnosed with cancer by a recognized medical practitioner. Record in MM/DD/YYYY format. If unknown, record "unknown"
Primary Site	Record the site of origin of the tumor. Record the subsite if known (i.e., UOQ breast, LL lung). If unknown, record "unknown". It is important to identify the primary site and not a metastatic site.
Histology	Record the histologic cell type of the tumor (ie. mucinous adenocarcinoma; infiltrating ductal CA
Place of Diagnosis	If the patient was diagnosed elsewhere, record the facility name and location. If unknown, record "unknown"

Treatment Information	
Treatment	Record all first-course treatment that the patient received. Do not record second-course treatment. First-course treatment includes all cancer-directed treatment modalities given by clinicians at the time of diagnosis. When recording treatment, write the type of treatment, the date the treatment was received or began and where performed.

Follow Up / Patient Status	
Date Last Seen	Record the date the patient was last seen or date of death in MM/DD/YYYY format.
Vital Status	Check the vital status of the patient as of the date last seen.
Cancer Status	Check the patient's cancer status as of the date the patient was last known to be alive or dead..
If Expired, Place of Death	If patient expired, record the place of death. If unknown, record "unk".
Cause of Death	If patient expired, record the cause of death. If unknown, record "unk".

Completed by	
Form Completed By	Record the full name of the person completing the form.
Date Completed	Record the date completed.