



CANCER CONCERN IDENTIFICATION FORM
 NORTH DAKOTA STATEWIDE CANCER REGISTRY
 UNIVERSITY OF NORTH DAKOTA
 SCHOOL OF MEDICINE AND HEALTH SCIENCES
 DEPARTMENT OF PATHOLOGY
 SFN 51874 [revised 8-22]

Inquiry received from:	
Facility/Clinic/Individual	
Mailing Address	
City, State, Zip	
Phone	

NDS&CR Use Only
Date Received: _____
Date Inquiry Closed: _____
Completed by: _____

Please complete the following with information on the INDIVIDUAL DIAGNOSED WITH CANCER.	
ND Geographic area cancer located	
Length of time living with cancer (number of months/years)	
Info on persons affected -	
Name	
Sex	
Race	
Date of birth	
Occupation [parents occupation if reporting on a child]	
Contact Person [family/friend]	
Address - street, city, county	
Length of time living at address at time of diagnosis	
Telephone number	
Type of cancer	
Diagnosis date	
Suspected exposure	
Physician Name	
Medical facility/Physician address	
Other information	