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 11-12]

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

NDSCR 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/frield]***	
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	