New Jersey Department of Health
Cancer Epidemiology Services
PO Box 369, Trenton, NJ 08625-0369
Phone: (609) 633-0500 Fax: (609) 633-7509

FOR OFFICE USE ONLY

CTR Number: _____

DENTIST REPORT FORM (09800)

Physician Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Patient Name | **Date of Birth** | **Social Security Number**

Patient Address | **Race/Ethnicity** | **Marital Status** | **Sex**

City, State, Zip Code | **Occupation** | **Industry**

Primary Site/Laterality of this cancer *(attach pathology report)*: _____

Histology Type of this cancer: _____

Date this cancer was FIRST DIAGNOSED: ____/____/____
Month/Day/Year

Initial visit for this cancer: ____/____/____
Month/Day/Year

Most recent visit for this cancer: ____/____/____
Month/Day/Year

STAGE INFORMATION *(Please refer to AJCC Cancer Staging Manual.)*

Primary Tumor (T) _____ **Regional Lymph Nodes(N)** _____ **Direct Metastasis (M)** _____ **Stage Group** _____

Tumor Size: _____
For malignant melanomas, record size, depth and thickness

Tumor Markers: _____ _____
Name *Results*

LDH Results _____ **Clinical Lymph Node Status @ Dx:** _____

Did this patient receive any treatment for this cancer? ☐ **Yes** ☐ **No** **If "Yes," please complete the following:**

Active Surveillance/watchful waiting? ☐ **Yes** ☐ **No**

Surgery *(specify type)*	*(margin status)*	**Month** / **Day** / **Year**
Radiation *(specify agents, duration, 1st course or subsequent)*		**Month** / **Day** / **Year**
Chemotherapy *(specify agents, duration, 1st course or subsequent)*		**Month** / **Day** / **Year**
Hormone *(specify type, duration)*		**Month** / **Day** / **Year**
Immunotherapy/Other Treatment *(specify type, duration)*		**Month** / **Day** / **Year**

Referred to Physician/Hospital:

Provider Name | *Address, Suite, City, Zip* | *Phone Number*

USE BACK OF FORM FOR ADDITIONAL COMMENTS