**REPORTER IDENTIFICATION**

FACILITY NAME: ABSTRACTOR INITIALS:

PHYSICIAN’S NATIONAL PROVIDER ID (NPI) #:

FACILITY ID # (Assigned by MCR, if known) :

MEDICAL RECORD # (if applicable):

**PATIENT** **DEMOGRAPHICS**

PATIENT NAME:

SOC SEC #: DATE OF BIRTH: / /

YYYY MM DD

Patient Residential Address:

Patient Residential Address:

City/State/Zip: , ,

County of Residence:

**GENDER (check one):** **[ ]** Male [ ]  Female [ ]  Other **PLACE (Country or U.S. State) OF BIRTH** (if known):

**RACE** (check one): [ ]  White [ ]  Black [ ]  American Indian [ ]  Asian Indian

[ ]  Asian/Pacific Islander (specify country if known)

[ ]  Other, specify [ ]  Unknown

**SPANISH/HISPANIC ORIGIN** (include country of origin if Hispanic): [ ]  Hispanic/Latino

[ ] Non-Hispanic [ ] Unknown

**OCCUPATION:**

**DIAGNOSIS/TUMOR INFORMATION**

**Date of Initial Diagnosis**: / / **Site of Tumor***:***Prostate – C619**

YYYY MM DD

**Size of Tumor** (enter tumor size in cm): ●

**Type of Tumor (Histology)**:

**Behavior**: [ ]  Benign [ ]  Borderline Tumor [ ]  In-situ [ ]  Malignant [ ]  Unknown

**Grade** (if stated): [ ]  Grade I [ ]  Grade II [ ]  Grade III [ ]  Grade IV [ ]  Unknown/not stated in report

**Metastatic Disease**: [ ]  Yes Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No [ ]  Unknown

**AJCC 7 STAGING**

If physician staging information was available, please provide the following:

**T** \_\_\_\_\_\_\_\_ **N**  **M**  **Stage**

**PROSTATE Tumor Characteristics** (for Staging). Check ‘Yes’ box if condition is present and/or described in the pathology report:

**DRE Performed**: [ ]  Yes [ ]  No Date:       **Imaging Studies**: [ ]  Yes [ ]  No Date:       Describe:

**Total Number of Core Needle Biopsies: Total Number of Core Needle Biopsies Positive:**

**PSA Level:**  ● **Gleasons Score:** + = **or total**

Positive [ ]  Yes [ ]  No [ ]  Unknown Please indicate method Gleason score was decided:

 Prostectomy [ ]  Autopsy [ ]  TURP [ ]  Needle Core Biopsy [ ]

**Choose only one that best describes the tumor, then skip to TREATMENT INFORMATION.**

In situ: noninvasive; intraepithelial [ ]  Yes [ ]  No Date:

***If the prostate cancer is considered “clinically Inapparent”, choose the selection that best describes the tumor:***

Number of foci or percent involved tissue not specified [ ]  Yes [ ]  No Date:

Incidental histologic finding in **5% or les**s of tissue resected [ ]  Yes [ ]  No Date:

Incidental histologic finding **more than 5%** of tissue resected [ ]  Yes [ ]  No Date:

Tumor identified by needle biopsy, e.g., for elevated PSA [ ]  Yes [ ]  No Date:

***If the prostate cancer is considered “clinically apparent”, choose the selection that best describes the tumor:***

Involvement in one lobe, NOS [ ]  Yes [ ]  No Date:

Involves one half of one lobe or less [ ]  Yes [ ]  No Date:

Involves more than one half of one lobe, but not both lobes [ ]  Yes [ ]  No Date:

Involves both lobes [ ]  Yes [ ]  No Date:

Clinically apparent tumor confined to prostate, NOS or Localized, NOS, Confined to prostate, NOS,

Intracapsular involvement only [ ]  Yes [ ]  No Date:

Extension to periprostatic tissue; or Extracapsular extension (beyond prostatic capsule),

NOS; or Through capsule, NOS; or Periprostatic extension, NOS (Unknown if

seminal vesicle(s) involved) [ ]  Yes [ ]  No Date:

Extension to seminal vesicles (s) with or without microscopic bladder neck involvement [ ]  Yes [ ]  No Date:

Unilateral extracapsular extension; or Bilateral extracapsular extension; or extension to

seminal vesicle(s) [ ]  Yes [ ]  No Date:

Extension to or fixation to adjacent structures

other than seminal vesicles: Bladder neck; Bladder, NOS; Fixation, NOS;

Rectovesical (Denonvillier's) fascia; Rectum; external sphincter; extraprostatic

urethra (membranous urethra); Levator muscles; Skeletal muscle; NOS, Ureter(s) [ ]  Yes [ ]  No Date:

Extension to or fixation to pelvic wall or pelvic bone [ ]  Yes [ ]  No Date:

Further contiguous extension (Stage D2) including to: [ ]  Yes [ ]  No Date:
    Bone, Other organs, Penis, Sigmoid colon, Soft Tissue other than periprostatic

No evidence of primary tumor [ ]  Yes [ ]  No Date:

Extension unknown, Primary tumor cannot be assessed [ ]  Yes [ ]  No Date:

Not documented in patient record

**TREATMENT INFORMATION**

Check response to indicate procedures were completed. **Check as many as apply**. If response is ‘Yes’ please indicate date of procedure.

**SURGERY**

None; no cancer-directed surgery of primary site **Reason**

 Date:

Local tumor destruction or excision, NOS [ ]  Yes [ ]  No Date:

Transurethral resection (TURP), NOS [ ]  Yes [ ]  No Date:

TURP patient has suspected/known cancer [ ]  Yes [ ]  No Date:

Cryoprostatectomy [ ]  Yes [ ]  No Date:

Laser [ ]  Yes [ ]  No Date:

Hyperthermia [ ]  Yes [ ]  No Date:

Other method of local resection or destruction [ ]  Yes [ ]  No Date:

Subtotal or simple prostatectomy, NOS [ ]  Yes [ ]  No Date:

Less than total prostatectomy, NOS [ ]  Yes [ ]  No Date:

Radical prostatectomy, NOS; total prostatectomy, NOS [ ]  Yes [ ]  No Date:

Prostatectomy **with** en bloc resection of other organs;

pelvic exenteration [ ]  Yes [ ]  No Date:

Prostatectomy, NOS [ ]  Yes [ ]  No Date:

Surgery, NOS [ ]  Yes [ ]  No Date:

Lymph Node Dissection [ ]  Yes [ ]  No Date:

If Lymph Nodes were involved, please describe name of lymph nodes or area, total number examined, and total number positive.

Total Number Nodes Examined:       Total Number Nodes Positive:

***Was a Pelvic Lymph Nodes Dissection performed?***  [ ]  Yes [ ]  No [ ]  Unknown

**OTHER TREATMENT** Choose all that apply, if yes – indicate starting date.

Watchful Waiting/Active Surveillance [ ]  Yes [ ]  No [ ] Unknown Date:

Orchiectomy [ ]  Yes [ ]  No [ ] Unknown Date:

Prednisone [ ]  Yes [ ]  No [ ] Unknown Date:

**Drug Therapy**

leuprolide (Lupron, Viadur, Eligard) [ ]  Yes [ ]  No [ ] Unknown Date:

goserelin (Zoladex) [ ]  Yes [ ]  No [ ] Unknown Date:

triptorelin (Trelstar) [ ]  Yes [ ]  No [ ] Unknown Date:

histrelin (Vantas) [ ]  Yes [ ]  No [ ] Unknown Date:

Casodex [ ]  Yes [ ]  No [ ] Unknown Date:

Eulexin [ ]  Yes [ ]  No [ ] Unknown Date:

Nilandron [ ]  Yes [ ]  No [ ] Unknown Date:

Abarelix (Plenaxis) [ ]  Yes [ ]  No [ ] Unknown Date:

docetaxel (Taxotere) [ ]  Yes [ ]  No [ ] Unknown Date:

mitoxantrone (Novantrone) [ ]  Yes [ ]  No [ ] Unknown Date:

estramustine (Emcyt) [ ]  Yes [ ]  No [ ] Unknown Date:

doxorubicin (Adriamycin) [ ]  Yes [ ]  No [ ] Unknown Date:

etoposide (VP-16) [ ]  Yes [ ]  No [ ] Unknown Date:

vinblastine (Velban) [ ]  Yes [ ]  No [ ] Unknown Date:

paclitaxel (Taxol) [ ]  Yes [ ]  No [ ] Unknown Date:

carboplatin (Paraplatin) [ ]  Yes [ ]  No [ ] Unknown Date:

vinorelbine (Navelbine) [ ]  Yes [ ]  No [ ] Unknown Date:

**Radiation Therapy** [ ]  Yes [ ]  No [ ] Unknown Date: Describe:

Indicate the type(s) of Radiation received: External Beam [ ]  Brachytherapy [ ]  CyberKnife [ ]

**Provide additional Information or referral information if the patient was referred to another physician for further treatment or care (if available):**

**NAME: SPECIALTY: \_\_\_\_\_\_\_\_**

**Please: ATTACH AND SEND A COPY OF THE PATHOLOGY/CYTOLOGY REPORT TO THIS MEDICAL RECORD ABSTRACT**

**Mail or Fax report to:**

**Myriddian, LLC., Maryland Cancer Registry**

**6711 Columbia Gateway Drive, Suite 475**

**Columbia, MD 21046**

**Fax: 240-833-4111**

**Questions? Call 1-866-986-6575 or 410-344-2851**