

## WISCONSIN CANCER REPORTING SYSTEM Cancer Report

See page 2 for the statutory reference and instructions to complete the form. Complete reporting requirements and definitions are available in the WCRS reporting manual, *WCRS Coding Manual*. <https://www.dhs.wisconsin.gov/wcrs/reporterinfo/manual.htm>

1. Last Name		2. First Name		3. Middle Name	
4. Maiden Name		5. Name Suffix	6. Alias Name	7. Social Security No.	
8. Address at Diagnosis		9. City at Diagnosis		10. State and Zip Code at Diagnosis	
11. Supplemental Address		12. County at Diagnosis	13. Date of Birth (YYYY/MM/DD)	14. Birthplace - State	
<b>Circle or specify codes</b>					
15. Sex 1 Male 2 Female 3 Hermaphrodite 9 Not stated/ 4 Transsexual, NOS Unknown 5 Trans. natal male 6 Trans. natal female		16. Race 01 White Asian (specify) _____ 02 Black Other (specify) _____ 03 American Indian 99 Unknown		17. Hispanic Origin Yes Code _____ (see page 2 for correct code) 0 No	18. Marital Status 1 Single 5 Widowed 2 Married 6 Domestic Partner 3 Separated 9 Unknown 4 Divorced
19a. Primary Site Text	19b. Subsite Text (if applicable)	20a. Histology Text (type of		20b. Behavior (in situ or malignant)	
21. Paired Organs (Laterality) 0 Not a paired site 4 Bilateral involvement 1 Right: origin of primary 5 Midline 2 Left: origin of primary 9 Paired site, but no information 3 Only one side involved		22. Grade/Differentiation 1 Well Differentiated 4 Undifferentiated/Anaplastic 7 Null cell 2 Mod. Well Differentiated 5 T-cell 8 NK cell (natural killer) cell 3 Poorly Differentiated 6 B-cell 9 Unknown/Not Stated/NA			
23. Diagnostic Confirmation 1 Histology 4 Microscopic 7 Radiographic 2 Cytology 5 Positive Lab/Marker 8 Clinical 3 Genetic Study 6 Visualization 9 Unknown		24. Occupation/Industry	25a. Accession Number ----- 25b. Sequence Number --	26. Medical Record No.	
27. Date Diagnosis	28. Date 1 <sup>st</sup> Contact	29. Facility Referred From		30. Facility Referred To	
31. Class of Case 00 Dx here, Tx elsewhere 32 Dx & Tx elsewhere 10 Dx and Tx here 40 Dx & Tx all done at Staff MD office only 20 Dx elsewhere, Tx here		32a. WCRS Facility Number ----- 32b. NPI Facility Number -----	33. Abstractor Phone		
		34. Abstractor Name			
35a. Primary Payer at Diagnosis 01 Not insured 31 Medicaid 63 Medicare with private supplement 02 Not insured, self-pay 35 Medicaid-Managed Care plan 65 TRICARE 10 Insurance, NOS 60 Medicare/Medicare, NOS 66 Military 20 Managed Care, HMO, PPO 61 Medicare with supplement, NOS 68 Indian/Public Health Service 21 Fee-for-Service 62 Medicare-Managed Care plan 99 Insurance status unknown				35b. Type of Reporting Source (hospital, clinic, physician office or other)	
36. SEER Summary Stage 2000 0 In situ 5 Regional NOS 1 Localized 6 Distant 2 Regional, Direct Ext. Only 7 Benign, borderline, NA 3 Reg. Lymph Nodes Only 8 Unknown/Unstaged 4 Reg., Direct Ext. & Lymph Nodes		37. CS Tumor Size (in millimeters)	38. CS Extension	39. CS Ext/Size Eval	
		40. CS Lymph Nodes	41. CS Mets at DX	42. CS Mets-Bone	

Completion of this form is mandatory under Chapter 255.04, Wisconsin Statutes. Personally identifiable information on this form (including social security number) is required by law and kept confidential per the requirements under Chapter 255.04; the information is necessary to assure complete and accurate data matching and consolidation and is used only for stated purposes in Chapter 255.04. Reporting this information to WCRS is not a violation of any person's responsibility for maintaining the confidentiality of patient health care records, as defined under s. 146.81(4).

Please complete the form by selecting the correct value provided in the box. Data values for some of the boxes did not fit within the form. The instructions and additional values for four of those data items are listed below. The number before each set of instructions corresponds directly to the numbered field on the actual form. Complete instructions are in the WCRS Coding Manual.

**16. Race**

- 01 White
- 02 Black
- 03 American Indian, Aleutian, or Eskimo
- 04 Chinese
- 05 Japanese
- 06 Filipino
- 07 Hawaiian
- 08 Korean
- 10 Vietnamese
- 11 Laotian
- 12 Hmong
- 13 Kampuchean
- 14 Thai
- 15 Asian Indian/Pakistani, NOS
- 16 Asian Indian
- 17 Pakistani
- 20 Micronesian, NOS
- 21 Chamorran
- 22 Guamanian, NOS
- 25 Polynesian, NOS
- 26 Tahitian
- 27 Samoan
- 28 Tongan
- 30 Melanesian, NOS
- 31 Fiji Islander
- 32 New Guinean
- 96 Other Asian, including Asian, NOS and Oriental, NOS
- 97 Pacific Islander, NOS
- 98 Other
- 99 Unknown

**17. Hispanic Origin**

- 0 Non-Spanish; non-Hispanic
- 1 Mexican (includes Chicano)
- 2 Puerto Rican
- 3 Cuban
- 4 South or Central American (except Brazil)
- 5 Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
- 6 Spanish, NOS  
Hispanic, NOS  
Latino, NOS
- 8 Dominican Republic
- 9 Unknown whether Spanish or not

**(65.) (67.) Reason for No (Surgery) (Radiation)**

- 0 (Surgery) (Radiation) of the primary site was performed.
- 1 (Surgery) (Radiation) of the primary site was not performed because it was not part of the planned first-course treatment.
- 2 (Surgery) (Radiation) of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
- 5 (Surgery) (Radiation) of the primary site was not performed because the patient died prior to planned or recommended surgery.
- 6 (Surgery) (Radiation) of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first-course therapy. No reason was noted in the patient's record.
- 7 (Surgery) (Radiation) of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
- 8 (Surgery) (Radiation) of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
- 9 It is unknown if (surgery) (radiation) of the primary site was recommended or performed. Death certificate only cases and autopsy only cases.

43. <b>CS Mets-Brain</b>	44. <b>CS Mets-Liver</b>	45. <b>CS Mets-Lung</b>	46. <b>SSF1</b>	47. <b>SSF2</b>	48. <b>SSF3</b>	49. <b>SSF8</b>	50. <b>SSF9</b>	
51. <b>SSF10</b>	52. <b>SSF11</b>	53. <b>SSF12</b>	54. <b>SSF13</b>	55. <b>SSF14</b>	56. <b>SSF15</b>	57. <b>SSF16</b>	58. <b>SSF17</b>	59. <b>SSF25</b>
60a. <b>Following MD Name &amp; City or WI Lic. No.</b>			60b. <b>Following MD NPI No.</b>		61. <b>No. of Nodes Examined</b>		62. <b>No. of Nodes Positive</b>	
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<b>Treatment</b>	<b>Reporting Facility Tx</b>	<b>Other Facility Tx</b>	<b>Other Facility Name</b>			<b>Date</b>		
63. Surgery of Primary Site								
64. Scope/Regional LN Surg								
65. Reason For No Surgery								
66. Radiation Modality								
67. Reason For No Radiation								
68. Surgery/Radiation Seq.								
69. Chemotherapy								
70. Hormone Therapy								
71. BRM Immunotherapy								
72. Transplant or Endocrine								
73. Surgery/Systemic Seq.								
74. Other Tx (clinical trial, etc)								
75. Tx Status Summary								
76. <b>Vital Status</b>	0 Dead	1 Alive	77. <b>Date of death (if deceased)</b>			78. <b>Place of Death - State</b>		

**REQUIRED TEXT FIELDS (OR ATTACH SUPPORTING DOCUMENTATION)**

PE (include race, age, sex, previous history of cancer)

X-RAY/SCANS/SCOPES (include dates, tumor size, lymph nodes involved, metastases)

LABS & OP (dates, results, type of OP procedure)

PATHOLOGY (cytology or histopathology information, tumor size, residual tumor, cell type, grade)

STAGING (include text to justify codes in boxes 36-59 and physician documented TNM and stage group, if available)

RX SURGERY (first course planned surgery – date and type)

RX RADIATION (beam and or other – include specific type and date radiation started)

RX SYSTEMIC (Chemo, Hormone, BRM, Transplant/Endocrine – include specific type, date started or reason not given)

MISC/REMARKS