

**WISCONSIN CANCER REPORTING SYSTEM
 CANCER REPORT – FOR CASES DIAGNOSED 2004-2015**

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

7. 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.

The WCRS Coding Manual, Appendix VI, lists the sites for which the SSF codes in boxes 46 – 59 are required. The *Collaborative Staging Manual Schema website* (<https://cancerstaging.org/cstage/schema/Pages/version0205.aspx>) contains the site-specific rules for all items in boxes 37-59.

43. CS Mets-Brain	44. CS Mets-Liver	45. CS Mets-Lung	46. SSF1	47. SSF2	48. SSF3	49. SSF8	50. SSF9	
51. SSF10	52. SSF11	53. SSF12	54. SSF13	55. SSF14	56. SSF15	57. SSF16	58. SSF17	59. SSF25
60a. Following MD Name and City or WI Lic. #			60b. Following MD NPI# -----		61. # of Nodes Examined		62. # of Nodes Positive	

Treatment	Treatment Type (lumpectomy, 5FU, IMRT, etc.)	Date	Performed at Reporting Facility (Y/N)
63. Surgery of Primary Site			
64. Scope of Regional LN Surg			
65. Reason For No Surgery			
66. Radiation Modality			
67. Reason For No Radiation			
68. Chemotherapy			
69. Hormone Therapy			
70. BRM Immunotherapy			
71. Transplant or Endocrine			
72. Other Tx (clinical trial,etc.)			
73. Vital Status 0 Dead 1 Alive		74. Date of death ___/___/_____	75. Place of Death – State _____

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 AND 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)

MISCELLANEOUS/REMARKS

Date Case Completed: ___/___/___