

**WISCONSIN CANCER REPORTING SYSTEM
 CANCER REPORT – FOR CASES DIAGNOSED 2016 OR LATER**

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		01 White		Asian (specify) _____	
5 Trans. natal male		02 Black		Other (specify) _____	
6 Trans. Natal female		03 American Indian		99 Unknown	
17. Hispanic Origin		18. Marital Status		Yes Code _____	
(see back page for correct 'Yes' code)		1 Single		5 Widowed	
0 No		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 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				8 NK cell (natural killer) cell	
				9 Unknown/Not Stated/NA	
				6 B-cell	
23. Diagnostic Confirmation		24. Occupation/Industry		25a. Accession Number	
1 Histology				_____	
4 Microscopic				25b. Sequence Number	
7 Radiographic				____	
2 Cytology					
5 Positive Lab/Marker					
3 Genetic Study					
6 Visualization					
9 Unknown					
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		32b. NPI Facility Number	
		10 Dx and Tx here		_____	
		40 Dx & Tx all done at Staff MD office only			
		20 Dx elsewhere, Tx here			
35a. Primary Payer at Diagnosis		35b. Type of Reporting Source (hospital, clinic, physician office, or other)			
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	
36. SEER Summary Stage 2000		37. Tumor Size Summary (in millimeters)		38. TNM Clinical T	
0 In situ		5 Regional NOS		39. TNM Clinical N	
1 Localized		7 Distant			
2 Regional direct ext. only		8 Benign, borderline, NA		40. TNM Clinical M	
3 Reg. lymph nodes only		9 Unknown/unstaged		41. Clinical Descriptor	
4 Reg., direct ext. and lymph nodes				42. TNM Clinical Stage Group	

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

(71.) (73.) 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 48 – 59 are required for 2016 diagnoses. The *AJCC Cancer Staging Manual, Seventh Edition*, contains the coding rules for all TNM data items in boxes 38-47, 60-65.

43. TNM Path T	44. TNM Path N	45. TNM Path M	46. Path Descriptor	47. TNM Path Stage Group	48. SSF1	49. SSF2	50. SSF5	
51. SSF6	52. SSF8	53. SSF9	54. SSF10	55. SSF11	56. SSF13	57. SSF14	58. SSF15	59. SSF16
60. Bone Metastases __ Yes __ No	61. Brain Metastases __ Yes __ No	62. Liver Metastases __ Yes __ No	63. Lung Metastases __ Yes __ No	64. LN Metastases __ Yes __ No	65. Other Metastases __ Yes __ No			
66a. Following MD Name and City or WI Lic. #			66b. Following MD NPI# -----	67. # of Nodes Examined		68. # of Nodes Positive		

Treatment	Treatment Type (lumpectomy, 5FU, IMRT, etc.)	Date	Performed at Reporting Facility (Y/N)
69. Surgery of Primary Site			
70. Scope of Regional LN Surg			
71. Reason For No Surgery			
72. Radiation Modality			
73. Reason For No Radiation			
74. Chemotherapy			
75. Hormone Therapy			
76. BRM Immunotherapy			
77. Transplant or Endocrine			
78. Other Tx (clinical trial, etc.)			
79. Vital Status 0 Dead 1 Alive	80. Date of death __/__/____	81. 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 36-65 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: ____/____/____