CTR & ID # (ACR USE ONLY):

ARIZONA CANCER REGISTRY
MELANOMA REPORT FORM

THE GRAY SHADED AREAS MUST BE COMPLETED EVEN IF THE DEMOGRAPHIC OR PATH REPORT IS ATTACHED.

REPORTING FACILITY (Name, Address, and Phone Number)

REPORTING PHYSICIAN

IF Dx ELSEWHERE:
Facility name/place

☐ NOT MY PATIENT
Attending physician name/contact information:

PATIENT IDENTIFICATION

PATIENT NAME (Last), (First) (Middle) (Maiden or Aliases)

PATIENT'S ADDRESS AT DIAGNOSIS (Street, City, State, Zip Code) MAY ATTACH COPY OF DEMOGRAPHIC REPORT

PATIENT'S CURRENT ADDRESS (Street, City, State, Zip Code)

SOCIAL SECURITY #:

DATE OF BIRTH: (mm/dd/yyyy)

SEX: ☐ Male ☐ Female

RACE : (check one) ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Other

HISPANIC ORIGIN: (check one) ☐ Yes ☐ No

DOES PATIENT HAVE HISTORY OF OTHER CANCER? ☐ Yes ☐No ☐ Unknown
If yes, what type & when diagnosed?

PATIENT'S USUAL INDUSTRY:

USUAL OCCUPATION:

CANCER IDENTIFICATION *ATTACH COPY OF PATH REPORT*

DATE OF DIAGNOSIS: (mm/dd/yyyy)

PRIMARY SITE : (with description, i.e. skin, right lower arm)

LATERALITY: (designate right or left, check one)
☐ Right ☐ Left ☐ Midline ☐ Unknown

SUBTYPE: (Type of melanoma, i.e. superficial spreading melanoma)

CLINICAL DIAMETER OF MELANOMA:(In millimeters)

SURGICAL DIAGNOSTIC PROCEDURE:
Biopsy: ☐ Shave ☐ Punch ☐ Excisional Biopsy ☐ Incisional

TREATMENT (1st Course) *ATTACH COPY OF PATH REPORT*

SURGICAL RESECTION: (insert margins by surgery indicated)

☐ Local Tumor Excision

With ________________ cm margin

☐ Mohs – Final margin size ☐<=1cm or ☐>1cm

☐ Other(specify) ____________Final margin size ☐<=1cm or ☐>1cm

Date (mm/dd/yyyy) ________________________________

Are the margins clear? (if applicable): ☐Yes ☐No

TYPE OF Tx AFTER SURGERY: (check all that apply) ☐ None

☐ Radiation ☐ Chemotherapy ☐ Hormone ☐ Immunotherapy

☐ Unknown ☐ Other (specify)______________________________

Date: (mm/dd/yyyy) ________________________________

Where Performed: ____

FOLLOW-UP

PATIENT STATUS: (check one)
☐ Alive ☐ Expired As of what date? (mm/dd/yyyy) ________________

CANCER STATUS: (check one)
☐ No evidence ☐ Evidence ☐ Unknown

FOLLOW-UP PHYSICIAN: (First) (Last)

STAGE OF DISEASE

DESCRIPTION OF EXTENSION: IF PATH REPORT ATTACHED NO NEED TO COMPLETE DESCRIPTION OF EXTENSION.

Measured Thickness (depth) of Tumor (Breslow's): ____________________mm

Clark Level:
☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V

Ulceration: ☐ Absent ☐ Present ☐ Not Reported

Mitotic Count:
☐ Absent ☐ Present/Rate ______________ ☐ Not Reported

DESCRIPTION OF INVASION INTO THE LAYERS OF THE DERMIS, IF CLARK LEVEL NOT REPORTED

DIAGNOSTIC CONFIRMATION: ☐ Histology ☐ Cytology
☐ Other (specify)_________________________________

REGIONAL LYMPH NODES: (Regional lymph node involvement)

Clinical palpable nodal adenopathy: ☐ No ☐ Yes ☐ Unk

Histologic nodal involvement: ☐ No ☐ Yes ☐ Unk

Sentinel Lymph Node Biopsy: ☐ Neg ☐ Pos

Date: (mm/dd/yyyy) ________________________________

Lymph Node Dissection: ☐ Neg ☐ Pos

Date: (mm/dd/yyyy) ________________________________

IF NODAL INVOLVEMENT, INDICATE WHICH BASINS POSITIVE

DISTANT INVOLVEMENT AT TIME OF DX:
☐ No ☐ Yes ☐ Unknown

IF YES, INDICATE SITES

Return Completed Form To: **ARIZONA CANCER REGISTRY**
150 N. 18th Avenue, Suite 550, Phoenix, Arizona 85007
Questions: Voice (602) 542-7320
Fax (602) 542-7362