

INSTRUCTIONS FOR COMPLETING THE MELANOMA REPORT FORM

ARIZONA CANCER REGISTRY (REVISED 2.26.2025) PAGE 1 OF 3

Facility Information

REPORTING FACILITY (Name, Address, and Phone Number)	REPORTING PROVIDER
IF Dx ELSEWHERE: Facility name/place	☐ NOT MY PATIENT Attending provider name/contact information:

- **Reporting Facility:** Record the full name of the reporting clinic.
- **Reporting Provider:** Record the full name of the reporting MD/DO/PA/NP. This provider receives ‘credit’ in for this case in the annual **Melanoma Task Force Newsletter**.
- **If Dx Elsewhere:** Record the full name of the facility (NOT Pathology Lab) that diagnosed the patient.
- **Not My Patient:** Check this box if your organization will not be following this patient and provide attending providers name.

Patient Identification

(If the demographic report is attached and it includes any of the following data items, those data items do not need to be entered on the Melanoma Report Form.)*

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:	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:	

- **Patient Name:** Record the full name.
- **Patient's Address at Diagnosis:** Must be recorded for melanoma to be included in the registry as an incident case for Arizona. Record the permanent home address at the time of diagnosis; not a temporary relocation for treatment. Street address takes priority over post office box number.
- **Patient's Current Address:** Record the patient's current address if different than the address at diagnosis. A temporary relocation address or post office box number may be recorded in this field.
- **Social Security #:** Record the patient's social security number. Do not record a spouse's number.
- **Date of Birth:** Record in mm/dd/yyyy format.
- **Sex:** Check the appropriate box.
- **Race (check one):** Check the appropriate box; if American Indian, if known record the tribe.
- **Hispanic Origin (check one):** Check if the patient considers himself or herself to be of Hispanic origin.
- **Does Patient Have a History of Other Cancer?:** If the patient has a history of cancer, record the type and date when they were diagnosed. For example, check yes, prostate, 12/2018.
- **Patient's Industry:** Record the primary type of activity carried on by the business or industry where the patient was employed for most of their life prior to the diagnosis of cancer, i.e. hospital, building construction. If usual industry is not available or is unknown, record the patient's current or most recent business/industry. If no information record “unk.”
- **Occupation:** Record the patient's usual occupation of work performed during most of their life prior to the diagnosis of cancer, i.e. registered nurse, carpenter. Do not record retired. If information is not available or is unknown, record the current or most recent occupation. If no information available record “unk.”

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Cancer Identification

(If the pathology report is attached and includes those data items specified on the Melanoma Report Form where **ATTACH COPY OF PATH REPORT** is indicated, those data items do not need to be entered on the Melanoma Report Form.)

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

▪**Date of Diagnosis:** Record in mm/dd/yyyy format. The date of diagnosis refers to the first diagnosis of this tumor by any recognized medical practitioner.

▪**Primary Site:** Record the site of origin of the tumor. It is important to identify the primary site and not a metastatic site. Example: skin, right lower arm.

▪**Laterality:** Check the appropriate box.

▪**Subtype:** Record type of melanoma. Example: superficial spreading melanoma.

▪**Clinical Diameter of Melanoma:** Record the clinical diameter of the melanoma in millimeters. Record the tumor size from the primary site and not a metastatic site. Tumor size for multiple tumors within a single primary is to be coded to the size of the largest tumor. If unknown, record "unk".

▪**Surgical Diagnostic Procedure:** Check the appropriate procedure performed at diagnosis.

Stage of Disease

Description of Extension

- Measured Thickness (depth) of Tumor (Breslow's):** Record in millimeters.
- Clark Level/Ulceration:** Check appropriate box.
- Mitotic Count:** Check appropriate box, if present include rate of mitoses. Usually recorded as the rate of mitosis per square mm.
- Description of invasion into the layers of the dermis:** Record if Clark's not reported.
- Diagnostic Confirmation:** Check appropriate box. Indicates method of diagnosis.

Regional Lymph Nodes

- Clinical palpable nodal adenopathy:** Check appropriate box. Information usually from the physical exam.
- Histologic nodal involvement:** Check appropriate box. Information from pathology report.
- Indicate lymph node surgery(ies) and date(s):** Sentinel Biopsy and/or Dissection.
- If nodal involvement, then indicate which basins positive, i.e. axillary.**

Distant Involvement

- Distant Involvement at Time of Dx:** Indicate whether distant

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:

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Treatment

Please attach appropriate supporting documentation (surgical pathology report, radiation summary, etc.).

Surgical Resection: Check appropriate surgery(ies). Insert margins (cm) by surgery(ies) indicated. Use the 'Mohs' check box for Mohs surgery(ies) performed on the same day. Use the 'Slow Mohs' check box for Mohs surgery(ies) performed on different days.

▪**Date:** Record in mm/dd/yyyy format.

▪**Are the margins clear:** Check appropriate box. Indicate final status of the surgical margins after most definitive resection of the tumor.

▪**Type of Tx:** Indicate all first course of treatment provided to the patient.

▪**Date:** Record in mm/dd/yyyy format.

▪**Where Performed:** Indicate where treatment performed.

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

☐ Slow Mohs _____ 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

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 PROVIDER: (First) _____ (Last) _____

▪**Patient Status:** Check the appropriate status. Enter date in proper format.

▪**Cancer Status:** Indicates the patient's melanoma status reported for the date indicated above.

▪**Follow-up Provider:** List the provider who will be following the patient for this melanoma.

Frequently Asked Questions

FAQs

- **I attached a copy of the patient's demographic sheet. Do I still fill out the rest of the form?** Yes, a copy of the demographic report only serves as a substitute for the 'Patient Identification' section of the form.
- **My clinic only did the follow-up excision on this patient. Do I still need to send a copy of the initial biopsy report?** Yes, when reporting a Melanoma case please include a copy of the pathology report for all procedures completed. Our goal is to receive documentation to tell the full story of that Melanoma from time of diagnosis until clear margins were obtained.
- **This patient opted for non-surgical treatment. Now what?** Please include a copy of a provider's statement documenting the patient's non-surgical treatment for that Melanoma.
- **This patient uses a P.O. Box for an address. Is that allowed?** Please provide the patients complete physical Arizona address when reporting to the Arizona Cancer Registry. Only list the P.O. Box if you are unable to obtain the patients physical address.
- **How long do I have to report a case before it is considered late?** Per Arizona Revised Statute §36-133 providers and clinics should report their cases to the Arizona Cancer Registry within 90 calendar days.
- **Is "Atypical Intraepithelial Melanocytic Proliferation" a reportable diagnosis?** The terminology "Atypical Intraepithelial Melanocytic Proliferation" on its own is not reportable. The pathology report must include the phrase "Melanoma In Situ" for the case to be considered reportable.
- **Where do I send my cases?** If your office reports 50 cases or less a year, please fax the case reports to our secure fax line at 602-542-7362. If your office reports more than 50 cases a year, please contact the Operations Manager at azcancerregistry@azdhs.gov to request access to report via a secure online portal called Web Plus.