TAMIL NADU CANCER REGISTRY PROJECT (TNCRP)

(A joint project of the Cancer Institute (WIA), Chennai - 600020 & Dept of Health & Family Welfare, Government of Tamil Nadu)
38. Sardar Patel Road, Chennai - 600 036.
Tel: 044- 22350340; **Fax:** 044- 22354508; **Email:** tncrp@cancerinstitutewia.org

TN Govt. Health & FW dept.G.O. No. 132 17.04.2012 **TN Govt. Health & FW dept. G.O. No. 66 22.02.2018**

CANCER NOTIFICATION FORM

(To be filled for each cancer case by TNCRP staff or authorized persons in respective institutions)

Notifying institution details

1. Institution Name : ..... .
2. District : ..... .
3. Department (if any) : ..... .
4. OP/IP/Dept. No. : ..... .

Tick [✓] the applicable :

5.Cervical Cancer ☐ Breast Cancer ☐ Oral Cancer ☐ Others ☐

6. Was the patient identified under cancer screening programme of Govt. of Tamil Nadu a. Yes ☐ b. No ☐

5.

For office use only

TNCRP No.: ☐☐/☐☐☐☐☐☐☐ Notification form status : 1. Completed 2. Pending 3. Duplicate 4. Deleted ☐

Patient Identification – needed to identify multiple notifications of same person

1. Name (in block letters : ..... 2. AADHAR No. .....
3. PHR No : ..... 4. NCD No : .....
5. Age : ..... DOB: ...../...../..... Sex: ..... 6. Father name : .....
7. Husband/Wife name : ..... 8. Other name(s) : .....
9. Address of usual residence : .....
.....
10. Rural ☐ Urban ☐ 11. CD Block : ..... 12. Taluk : .....
13. District : ..... 14. PIN code : ..... 15. Tel/Mobile No. .....

Cancer Information:

1. Date of consultation/admission : ...../...../..... 2. Date of 1st diagnosis : ...../...../.....
3. Most valid basis of cancer diagnosis :
   1. Histology (primary) 2. Histology (metastasis) 3. Cytology 4. Blood film/bone marrow 5. Imaging (X-ray/USG/CT etc.)
   6. Clinical only 7. Others (specify) .....8. DCO
4. Clinical stage of Disease **a.** localised (early cancer) **b.** Regional (Locally advanced) **c**. Distant metastasis **d**. unknown (NA)
5. Primary site : ..... ICD-O: ☐☐☐☐☐ ICD-10 : ☐☐☐☐☐
6. Histology : ……. ICD-O : ☐☐☐☐☐☐ Slide No. .....
7. If Registered from Pathology Lab only : Referral Dr. ..... .
   Hospital Name : ..... Place : ..... .
8. Tumour behaviour (✓) : [ ] In-situ [ ] Borderline [ ] Malignant
9. Treatment received (✓) : [ ] Surgery [ ] Radiotherapy [ ] Chemotherapy [ ] Hormone
   [ ] Others (specify) ..... [ ] No treatment
10. Date of Last Contact/Known alive: ___/___/___
11.Date of death (if any) : ...../...../. .....12. Cause of death : Cancer / Not cancer

Remarks : .....
.....

Date : ...../...../..... Name of person completing the form : ..... .

Please complete the form and transmit it through email or post. Thank you