Print Form

CAYMAN ISLANDS CANCER REGISTRY

CAYMAN ISLANDS HEALTH SERVICES AUTHORITY

P.O. Box 915, Grand Cayman KY1-1103, Cayman Islands

NONE MEDICAL REPORTING FORM

1. REGISTRY NO. _____ TO BE FILLED BY THE CICR

PLEASE PRINT CLEARLY

Personal Information

2.	Surname(s)				
3.	First name		4. Middle name(s)		
5.	Maiden name		6. Nickname(s)		
7.	Date of Birth	[dd/mm/yyyy]	8. Age		
9.	Country of Birth	Cayman Islands 99☐ ND	10. Sex	1☐ Male 2☐ Female 99☐ ND	
11.	Resident	1☐ Yes 2☐ No 99☐ ND	12. Year of last immigration to Cayman	[yyyy]	
13.	Caymanian	1☐ Yes 2☐ No 99☐ND	If No, Specify Nationality _____		
14.	Address	Current Address 99☐ND House/Apt Name/No. Street Name District Island Post Box #_____ Postal Code KY - Length of Residence: Years Months	Address at Diagnosis 99☐ND House/Apt Name/No. Street Name District Island Post Box # _____ Postal Code KY - Length of Residence: Years Months		
15.	Marital Status	1☐ Never Married 2☐ Legally Married 3☐ Legally Separated 4☐ Divorced 5☐ Widowed 99☐ ND			
16.	Ethnic Origin	1☐ Black 2☐ White 3☐ Hispanic 4☐ Asian 5☐ Mixed 98☐ Other 99☐ ND If Mixed or Other, Specify _____			
17.	Religion	1☐ Christian 2☐ Hindu 3☐ Muslim 4☐ Rastafarian 5☐ None-denominational 0☐ None 98☐ Other 99☐ ND If Other, Specify _____			
18.	Driver's licence #		19. Parents country of birth	Mother_____ Father_____	
20.	Usual Occupation		21. Usual Industry		22. Time in Industry Years Months
23.	Potential Contributing Factors	1☐ History of Smoking 2☐ Regular Alcohol Consumption 3☐ Exposure to asbestos 4☐ Sedentary lifestyle 5☐ Poor Diet 6☐ Exposure to pesticides 7☐ Genetics/Family History If Other, Specify _____			
24.	If Yes to Genetic/Family history as a Potential contributing factor, Select all that apply and Specify Cancer	1☐ Father Type:	2☐ Mother Type:		
		3☐ Brother Type:	4☐ Sister Type:		
		5☐ Uncle Type:	6☐ Aunt Type:		
		7☐ Grandfather Type:	8☐ Grandmother Type:		
		9☐ Son Type:	10☐ Daughter Type:		
		99☐ ND			

Tumour information, Treatments and Outcome

25.	Site of Primary	
26.	Method of First detection	1☐ Clinical presentation (with symptoms) 2☐ Screening examination: Type _____ 3☐ Incidental finding: Test/Procedure_____ 4☐ Incidental finding at autopsy 98☐ Other, Specify _____ 99☐ ND Select all that apply

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27.	Date of first Consultation	[dd/mm/yyyy]			
28.	Date of first Biopsy	[dd/mm/yyyy]			
29.	Date of first Diagnosis	[dd/mm/yyyy]			
30.	Country of Diagnosis		31. Country of first treatment		
32.	Initial Treatment (within first 6 months of diagnosis) Select all that apply	1☐ Surgery	2☐ Radiotherapy	3☐ Chemotherapy	4☐ Immunotherapy
		5☐Hormonal Therapy	6☐ Cryotherapy	7☐ Laser Therapy	8☐ Palliative Therapy
		9☐ Complementary	10☐ Treated Abroad	If Other, Specify_____	
33.	Date of last contact with Dr	[dd/mm/yyyy]			
34.	Status	1☐ Alive	2☐ Deceased	3☐ Emigrated	99☐ ND
		* If patient is 'Deceased' please complete relevant Q's. If patient '**Alive**', '**Emigrated**' or '**ND**' selected then proceed to **Q. 38**			
35.	Date of Death	[dd/mm/yyyy]	36. Cause of Death	1☐ Dead of this cancer	2☐ Dead of other cause 99☐ ND
37.	Place of Death	1☐ HSA	2☐ CTMH	3☐ Home	4☐ Convalescent/Nursing Home
		98☐ Other	99☐ ND	If Other, Specify _____	
		Sources			
38.	Facility to contact	1☐ Hospital	2☐ Private Physician	3☐ Laboratory	4☐ Death Registry
		98☐ Other	If Other, Specify _____		Select all that apply
39.	Name of Facility				
	Name of Facility				
	Name of Facility				
	Name of Facility				
40.	Hospital/Clinic #		41. Autopsy #		
42.	Path/Histo Lab #		43. Radiotherapy #		
44.	Name of main Physician/Consultant				

ND = Not Documented

I give my consent to the Cayman Islands Cancer Registry (CICR) to review, extract, retain and utilize the data referenced in this document.

Date: [dd/mm/yyyy] Contact Number(s): _____

Signature of Patient or Next of Kin (on behalf of Patient):

If Next of Kin, specify relationship to patient: _____

Notes:

1. *The information obtained by the CICR is to be used for the sole purpose of research, statistic and programme development.*
2. *Any data utilized and released will be in aggregate format that cannot lead to the patients' identification.*

Received: _____ Verifier: _____

Date: _____ Date: _____

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