CAYMAN ISLANDS CANCER REGISTRY

CAYMAN ISLANDS HEALTH SERVICES AUTHORITY
P.O. Box 915, Grand Cayman KY1-1103, Cayman Islands
(345) 244-2560

DATA COLLECTION FORM

Your participation in the Cayman Islands Cancer Registry is voluntary. Should you choose to register, all information will be kept confidential and will be used for statistical purposes only.

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

PLEASE PRINT CLEARLY

Personal Information					
1.	Surname(s)				
2.	First name		3. Middle name(s)		
4.	Date of Birth	☐☐/☐☐/☐☐☐☐ [dd/mm/yyyy]	5. Age	☐☐☐	
6.	Country of Birth		7. Sex	1☐ Male	2☐ Female
8.	Mother's country of birth		Father's country of birth		
9.	Resident	1☐ Yes 2☐ No	10. Year of immigration to Cayman	☐☐☐☐ [yyyy]	
11.	Caymanian	1☐ Yes 2☐ No	If No, Specify Nationality _____		
12.	Address (at time of diagnosis)	District _____ Island_____ Length of Residence: Years ☐☐			
13.	Marital Status	1☐ Never Married 2☐ Legally Married 3☐ Legally Separated 4☐ Divorced 5☐ Widowed			
14.	Ethnic Origin	1☐ Black 2☐ White 3☐ Hispanic 4☐ Asian 5☐ Mixed 98☐ Other If Mixed or Other, Specify _____			
15.	Religion	1☐ Christian 2☐ Hindu 3☐ Muslim 4☐ Rastafarian 5☐ Non-denominational 0☐ None 98☐ Other If Other, Specify _____			
16.	Usual Occupation		17. Usual Industry		18. Time in Industry: Years ☐☐
19.	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☐ Family History of cancer If Other, Specify _____			
20.	If Yes to "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:	

PLEASE CONTINUE TO REVERSE SIDE

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Tumour information, Treatments and Outcome					
21.	Site of Primary (Type of cancer)				
22.	Date of first Diagnosis	[dd/mm/yyyy] ☐☐ / ☐☐ / ☐☐☐☐			
23.	Country of Diagnosis		24. Country of first treatment		
25.	Initial Treatment (within 6 months of diagnosis)	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_____	

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 Registrant: _____

This form may be returned to the Cancer Registrar at the e-mail address, or mailing address, listed below.

Amanda Nicholson, Cancer Registrar
Cayman Islands Health Services Authority
P.O. Box 915
Grand Cayman KY1-1103
Cayman Islands

Phone: (345) 244-2560
E-mail: Amanda.nicholson@hsa.ky

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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