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

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 $_{99}$☐ ND	
8.	Mother's country of birth		Father's country of birth		
9.	Resident	$_1$☐ Yes $_2$☐ No $_{99}$☐ ND	10. Year of immigration to Cayman	☐☐☐☐ [yyyy]	
11.	Caymanian	$_1$☐ Yes $_2$☐ No $_{99}$☐ ND	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 $_{99}$☐ ND			
14.	Ethnic Origin	$_1$☐ Black $_2$☐ White $_3$☐ Hispanic $_4$☐ Asian $_5$☐ Mixed $_{98}$☐ Other $_{99}$☐ ND If Mixed or Other, Specify _____			
15.	Religion	$_1$☐ Christian $_2$☐ Hindu $_3$☐ Muslim $_4$☐ Rastafarian $_5$☐ Non-denominational $_0$☐ None $_{98}$☐ Other $_{99}$☐ ND 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:	
		$_{99}$☐ ND			

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

If Next of Kin, specify relationship to patient: _____

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: _____

CONFIDENTIAL