CAYMAN ISLANDS CANCER REGISTRY

CAYMAN ISLANDS HEALTH SERVICES AUTHORITY
P.O. Box 915, Grand Cayman KY1-1103, Cayman Islands

SELF-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	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 98☐ Same as Current 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☐ Non-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

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: _____

CONFIDENTIAL