|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Personal Information | | | | | | | | | | | | | | | | | |
| 1. | Surname(s) |  | | | | | | | | | | | | | | | |
| 2. | First name |  | | | | | | | | 3. Middle name(s) | | | | | | | |
| 4. | Date of Birth | / / [dd/mm/yyyy] | | | | | | | | 5. Age at time of diagnosis | | | | | | | |
| 6. | Country of Birth |  | | | |  | | | | 7. Sex | 1🞎 Male | | | | 2🞎 Female | |  |
| 8. | Mother’s country of birth |  |  | |  | | 9. Father’s country of birth | | | | | |  | | | | |
| 10. | Are you a resident of the Cayman Islands | 1🞎 Yes | 2🞎  No | |  | | 11. Year of immigration to Cayman (if applicable) | | | | | | [yyyy] | | | | |
| 12. | Length of residence in Cayman (years) | [years] | | | | | | | | | | | | | | | |
| 13. | Are you Caymanian | 1🞎 Yes | 2🞎  No | | If No, Specify Nationality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| 14. | Address at time of diagnosis | District \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Island \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| 15. | Ethnic Origin | 1🞎 Black | | 2🞎 White | | | | 3🞎 Hispanic | | | | 4🞎 Asian | | | | 5🞎 Mixed | |
| 6🞎 Other | |  | | | | If Mixed or Other, Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| 16. | Usual Occupation |  | | | | | | | 17. Number of years in occupation | | | | | Years | | | |
| Tumour information | | | | | | | | | | | | | | | | | |
| 18. | Type of cancer diagnosed |  | | | | | | | | | | | | | | | |
| 19. | Date of first Diagnosis | / /  [dd/mm/yyyy] | | | | | | | | | | | | | | | |
| 20. | Country of diagnosis |  | | | | | | | | | | | | | | | |
| 21. | Country of first treatment |  | | | | | | | | | | | | | | | |
| 22. | First treatment received after diagnosis | 1🞎 Surgery 2🞎 Radiotherapy 3🞎 Chemotherapy 4🞎 Immunotherapy 5🞎 Hormonal therapy  6🞎 Cryotherapy 7🞎 Laser therapy 8🞎 Palliative therapy If other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| 23. | Morphology/ histopathological type | (IF UNKNOWN LEAVE BLANK) | | | | | | | | | | | | | | | |
| 24. | Type of test used to confirm diagnosis | 1🞎 Biopsy (histology of primary) 2🞎 Surgery 3🞎 Ultrasound 4🞎 Cytology  5🞎 Laboratory test –other 6🞎 Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |

I give my consent to the Cayman Islands Cancer Registry (CICR) to review, extract, retain and utilize the data referenced in this document, and to track and locate any missing or incomplete data items referenced above. I understand the information obtained by the CICR is to be used for the sole purpose of research, statistic and programme development, and that any data utilized and released will be in aggregate format that cannot lead to the registrant’s identification.

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

**Signature of registrant (required):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone: (345) 244-2560

E-mail: Amanda.nicholson@hsa.ky

Mailing address: Amanda Nicholson, Cancer Registrar

Cayman Islands Health Services Authority

P.O. Box 915

Grand Cayman KY1-1103

Cayman Islands

Physical address: Smith Road Centre, 150 Smith Road, George Town