CAYMAN ISLANDS CANCER REGISTRY

CAYMAN ISLANDS HEALTH SERVICES AUTHORITY

P.O. Box 915, Grand Cayman KY1-1103, Cayman Islands
(345) 244-2560

HSA
Committed to Caring for You

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

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 _____

PLEASE CONTINUE TO REVERSE SIDE

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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: Health Services Authority, 95 Hospital Road, George Town

Received: _____ Verifier: _____

Date: _____ Date: _____

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