State of Connecticut
Department of Public Health
Connecticut Tumor Registry
Patient Report Form

Last Name

First Name

Date of Birth

Visit date

Street Address

Town

State

Postal code

Social Security Number

Race (check all that apply)

- ☐ White
- ☐ Black
- ☐ American Indian/Alaska Native
- ☐ Asian/Pacific Islander
- ☐ Unknown

Facility/Provider Name:

Primary Site of Cancer

Histologic Type of Cancer

Surgeon

Other Physician

Procedure

Other Treatment

Referrals: Please indicate any provider the patient is referred to for treatment

Please fax completed form to: 860-706-1313. Please do not e-mail patient information.