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

Please complete all sections of this form.

Patient Information			
Last Name:		Race: (Check all that apply)	☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Other (specify): ☐ Unknown
First Name:			
Middle Name(s):			
Date of Birth:			
Street Address:			
Town/City:		Hispanic Ethnicity:	☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Zip Code:			
State:		Social Security Number:	

Cancer Information	
Visit Date:	
Primary Site of Cancer: (Enter text and ICD code if known)	
Histologic type of Cancer: (Enter text and ICD code if known)	
Surgeon:	
Other Physician:	
Procedure:	
Other Treatment:	

Referral Information: Please provide as much referral information as possible.		
Patient was referred to facility from:	Physician Name:	Hospital Name:
The patient was referred on to:	Physician Name:	Hospital Name:

Please fax completed form to: 860-509-7161. Please **do not** e-mail patient information.