Northwest Territories

N.W.T. DISEASE REGISTRY

CANCER REGISTRATION

Complete at first cancer diagnosis and again for each new primary cancer in accordance with the *Disease Registries Act.**

MEDICAL CONFIDENTIAL

PLEASE PRINT

PATIENT INFORMATION

Surname	Given Name(s)	Letter Prefix / Health Care Number
Birth Name (if applicable)		Sex ☐ Male ☐ Female
Place of Birth (city, town, or settlement)		Date of Birth (yy/mm/dd)
Community of Residence (city, town, or settlement)		Postal Code

DISEASE INFORMATION

Method of Diagnosis (check all that apply)	Primary Site	
☐ Biopsy	Histology/Morphology	
☐ Cytology	Date of Diagnosis (yy/mm/dd)	Laterality ☐ Left ☐ Right
☐ Diagnostic Imaging	Name and Location of Diagnostic Facility	Patient Status ☐ Alive ☐ Deceased
☐ Clinical	Name of Diagnosing Physician/Attending Physician/Nurse-in-Charge	
☐ Autopsy	Name/Address of Referral Physician	Date of Death: yy/mm/dd
☐ Unknown		☐ Unknown

PLEASE ATTACH COPIES OF REPORT(S) LISTED BELOW ONCE AVAILABLE**

Report Required	**Date of Report (yy/mm/dd)**	**Report Required**	**Date of Report (yy/mm/dd)**
☐ Discharge Summary		☐ Consultation Report(s)	
☐ History and Physical Exam		☐ Diagnostic Imaging Report(s)	
☐ Pathology Report(s)		☐ Other Laboratory Report(s)	
☐ Operative Report(s)		☐ Autopsy Report(s)	

TREATMENT INFORMATION

Treatment	**Date of Treatment (yy/mm/dd)**	**Place Treatment was Provided**
☐ Chemotherapy, Hormone Therapy		
☐ Immunotherapy		
☐ Radiotherapy		
☐ Surgery		
☐ Observation		
Report Completed by: (please print)	Signature X	Date - yy/mm/dd

*THIS FORM MUST BE COMPLETED FOR THE FOLLOWING REPORTABLE DISEASES, INCLUDING SUSPECTED CASES:

1. **Malignant neoplasms of any anatomic site: International Classification of Diseases, Tenth Revision: ICD-10, C00-C97**
2. **Carcinomas in situ: ICD-10, D00-D09**
3. **Neoplasms of uncertain behaviour and/or unspecified nature: ICD-10, D37-D48**
4. **Benign and borderline tumors of the brain and central nervous system are also reportable as of 04/01/01**

**Only include reports through to completion of surgery(ies) in the first course of treatment or information within four months of diagnosis (in the absence of disease progression), whichever is longer.

How to submit: By Medical Confidential Fax: 867-873-0442 OR Secure File Transfer to: PublicHealthRegistries@gov.nt.ca