REQUEST FOR FOLLOWUP
From

DEAR DR.
WOULD YOU BE SO KIND AS TO LET US KNOW THE STATUS OF YOUR PATIENT:

NAME:
SITE:
HISTOLOGY:
DATE OF BIRTH:

DIAGNOSED:
CUMULATIVE RX:
REGISTRY DATE OF LAST CONTACT:

PATIENT IS ALIVE:

Have you had any contact with the patient since

☐ YES: DATE ______ / / ______

☐ NO: ______
Comments

PATIENT STATUS

☐ Alive, no clinical evidence of this tumor
☐ Alive, with this tumor
☐ Alive, tumor status unknown

PATIENT IS DECEASED:

DATE OF DEATH: ______ / / ______

CAUSE OF DEATH: ______

PLACE OF DEATH: ______

AUTOPSY? ☐ YES ☐ NO ☐ UNKNOWN

CANCER STATUS AT TIME OF DEATH

☐ No evidence of any cancer at death
☐ Evidence of any cancer at death
☐ Unknown whether cancer present at death

MAY WE ATTEMPT TO CONTACT THE PATIENT IF NOT SEEN IN MORE THAN 15 MONTHS?

☐ YES ______ ☐ NO
Signature

FIRST RECURRENCE OF THIS TUMOR

DATE OF FIRST RECURRENCE: ______

SITE(S) OF FIRST RECURRENCE: ______

ANY NEW PRIMARIES: ______ SITE

IF THE PATIENT HAS HAD ANY ADDITIONAL TREATMENT FOR THIS TUMOR OTHER THAN LISTED ABOVE, PLEASE INDICATE:

TREATMENT	DATE	PLACE	TYPE ADMINISTERED
SURGERY	/ /		
RADIATION	/ /		
CHEMOTHERAPY	/ /		
HORMONAL	/ /		
BIOLOGICAL RESPONSE MODIFIERS	/ /		
OTHER	/ /		

IF THIS PATIENT'S PRIMARY FOLLOWUP IS BY A PHYSICIAN OTHER THAN YOURSELF,
PLEASE INDICATE NAME

______

REGISTRY USE

FORM R-15 REV. 10-89