CASEFINDING FOR COMPLETENESS OF REPORTING

The Texas Cancer Incidence Reporting Act (Chapter 82, Health and Safety Code) requires every health care facility, clinical laboratory, and health care practitioner center to submit cancer information for each reportable diagnosis.

Cases of cancer to be reported to the Texas Cancer Registry (TCR) include:

1. All neoplasms with a behavior code of two or three in the International Classification of Diseases for Oncology (ICD-O) 3rd edition (with certain exceptions).

2. All primary tumors (benign or malignant) occurring in any of the following sites:
   a. Brain (C71.0-C71.9), meninges (C70.0-C70.9), spinal cord (72.0), cauda equina (C72.1), cranial nerve or nerves (C72.2-C72.5), or any other part of the central nervous system (C72.8-C72.9);

   b. Pituitary gland (C75.1), pineal gland (C75.3), or crainopharyngeal duct (C75.2).

      NOTE: A non-malignant reportable CNS diagnosis can include the term neoplasm and tumor.

      NOTE: All tumors and neoplasms of the brain and CNS must have the morphology term listed in ICD-O-3. If the morphology term (code) is not in the ICD-O-3, then it is not reportable.

Casefinding is a system for identifying all eligible cases. Facility sources used to identify cases are disease indices, pathology and laboratory reports, patient logs, and similar resources. Refer to the Casefinding sources list on page 15. Every inpatient and/or outpatient admission with active disease and/or receiving cancer-directed therapy **must** be reported to the Texas Cancer Registry, regardless of the patient's state or country of residence**.**

Facilities that submit at least 95% of their cancer reports to the TCR are considered to be compliant.

CASEFINDING METHODS

There are two types of casefinding methods – *active and passive:*

Active casefinding: The personnel responsible for reporting obtain and review all sources for eligible cases.

Passive casefinding: The personnel responsible for reporting rely on others to notify the reporter of possible eligible cases.

Active casefinding is more comprehensive and precise. Passive casefinding is less accurate and there is the potential for missed cases. A combination of active and passive casefinding is a more effective method and ensures less missed cases. Casefinding procedures should be evaluated from time to time and amended as facility procedures or services change.

CASEFINDING SOURCES

1. Medical records department
   a. Disease indices
   b. Admission & discharge reports
2. Pathology department
   a. Histology reports
   b. Cytology reports
   c. Hematology reports
   d. Autopsy reports
3. Surgery department
4. Outpatient departments
5. Medical and diagnostic imaging
6. Radiation & medical oncology
7. Emergency Room reports

CASEFINDING PROCESS

Cooperation and a good working relationship between reporting personnel and other departments are essential for accurate case ascertainment. The reporter is responsible for identifying all casefinding sources under their facility licensure and arranging access to these sources, for example, rural health clinics, surgery centers across town or off campus.

A disease index including both inpatient and outpatient admissions will need to be obtained after medical records are completed and coded (monthly or quarterly). The index will need to be sorted **alphabetically** by last name and should include the following: last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-9 diagnosis codes and admission type. *Attachment A (*page 27) is an example of a disease index that can be used to design one for your facility. The following list includes some helpful hints for the casefinding process.

- Review your disease index for reportable cancer codes to insure your facility has reported all of your reportable cases to the TCR.
- Compare the patients with reportable codes on your disease index to the TCR Facility Data Report.
- Review the patient charts with reportable codes that are missing from the TCR Facility Data Report for reportability.
- Prepare an abstract for each reportable case missing from the TCR Facility Data Report.
- If a previously reported patient is found to have a multiple primary, assign the new primary the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information. If reporting on paper forms, the TCR will assign the registry number.

The following lists are intended to assist you, as the reporter, in identifying the reportable neoplasms for your facility.

REPORTABLE NEOPLASMS

- Malignant neoplasms (*exclusion noted below)*
- Benign and borderline neoplasms of central nervous system
- Carcinoma in-situ (*exclusion noted below)*
- Carcinoid, NOS *(excluding Appendix, unless stated to be malignant)*
- Pilocytic/juvenile astrocytoma is listed as 9421/1 in ICD-O-3, is reportable, and should be coded to 9421/3
- Squamous intraepithelial neoplasia grade III of vulva **[VIN]**, vagina **[VAIN]**, and anus **[AIN] beginning with 2001 cases.**

NOTE: All tumors, neoplasms of the brain and CNS morphology must have a code number in ICD-O-3. If the morphology does not have a code number, it is not reportable for 2004.

SPECIAL EXCLUSION NOTES:

1. Malignant neoplasms of the skin of genital sites **are reportable**. These sites include: vagina, clitoris, vulva, prepuce, penis, and scrotum.

2. Reportable skin tumors such as adnexal carcinomas (e.g., carcinomas of the sweat gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor **must be reported regardless of site**. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.

NON-REPORTABLE NEOPLASMS

- Basal and squamous cell carcinomas of the skin (8090-8110) **except genital sites**
- Epithelial carcinomas of the skin (8010-8045)
- Papillary and squamous cell carcinomas of the skin (8050-8084) **except genital sites**
- Malignant neoplasms, NOS of the skin (8000-8004)
- Carcinoma in-situ of the cervix (8012)
- Intraepithelial neoplasms of the cervix (8077/2) or prostate (8148/2)
- Borderline cystadenomas (8442, 8451, 8462, 8472, 8473), of the ovaries with behavior code "1" are **not** collected as of January 01, 2001
- Cyst, brain or CNS tumor that does not have an ICD-O-3 code as of January 01, 2004

EXAMPLES:

1. On 04/12/2004, a patient was diagnosed with cholesteatoma in the cerebral meninges. This is not a reportable CNS case for 2004.

2. On 11/03/2003 a patient was diagnosed with cholesteatoma in the cerebral meninges. This is a reportable case for 2003 and prior years.

COMPREHENSIVE REPORTABLE LISTS

The following lists are intended to aid the appropriate personnel (e.g. Information Services, Data Management) in the process of creating the disease index with the required reportable neoplasms and other ICD-9-CM codes. The reporter should review all admissions (inpatient and outpatient) with the following diagnosis codes for reportability.

ICD-9-CM CODES	DIAGNOSIS
CODE RANGES	**PREFERRED ICD-O-3 TERMINOLOGY**
140.0 *through* 208.9	Malignant neoplasms
225.0 *through* 225.9	Benign & Borderline Neoplasms of Central Nervous System
230.0 *through* 234.9	Carcinoma in-situ
235.0 *through* 238.9	Carcinoid, NOS (excluding appendix, unless stated to be malignant neoplasms of uncertain behavior)
239.0 *through* 239.9	Neoplasms of unspecified behavior
INDIVIDUAL CODES	**PREFERRED ICD-O-3 TERMINOLOGY**
042	AIDS (review records for AIDS-related malignancies)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
227.3	Pituitary (body, fossa, gland, lobe)
227.3	Craniopharyngeal (duct, pouch)
227.4	Pineal (body, gland)
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3)
238.7	Myelosclerosis with myeloid metaplasia (9961/3)
238.7	Essential thrombocythemia (9962/3)
238.7	Refractory cytopenia with multilineage dysplasia (9985/3)
238.7	Myelodysplastic syndrome with 5q-syndrome (9986/3)
238.7	Therapy-related myelodysplastic syndrome (9987/3)
273.2	Gamma heavy chain disease; Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
284.9	Refractory anemia (9980/3)
285.0	Refractory anemia with ringed sideroblasts (9982/3)
285.0	Refractory anemia with excess blasts (9983/3)
285.0	Refractory anemia with excess blasts in transformation (9984/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9931/3)

Admissions with the following procedure codes **must** be screened for reportable neoplasms.

ICD-9-CM CODES	PROCEDURE DESCRIPTION
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.8	Other specified prophylactic measure
V10.0 *through* V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, subsequent treatment and diagnosis date)
V58.0	Admission for radiotherapy
V58.1	Admission for chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0 *through* V76.9	Special screening for malignant neoplasm

The following are **exclusions** and **do not** need to be reported to the TCR:

MORPHOLOGY CODES	DIAGNOSIS/TERMINOLOGY
8000-8004	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix **beginning with 1996 cases**
8010-8045	Epithelial carcinomas of the skin
8050-8084	Papillary and squamous cell carcinomas of the skin **except genital sites**
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix **beginning with 1996 cases**
8090-8110	Basal cell carcinomas of the skin **except genital sites**
8148/2	Prostatic Intraepithelial Neoplasia

For cases diagnosed January 01, 2001 and forward, the following tables are terms that changed behavior codes from borderline to malignant, and malignant to borderline in the ICD-O-3.

These terms/codes **are reportable** starting with 01/01/2001and forward diagnoses:

2ND ED. CODE	TERM AS IT APPEARS IN ICD-O, 3RD ED.	3RD ED. CODE
89311	Endometrial stromal sarcoma, low grade (C54.1)	89313
89311	Endolymphatic stromal myosis (C54.1)	89313
89311	Endometrial stromatosis (C54.1)	89313
89311	Stromal endometriosis (C54.1)	89313
89311	Stromal myosis, NOS (C54.1)	89313
93931	Papillary ependymoma (71._)	93933
95381	Papillary meningioma	95383
99501	Polycythemia vera	99503
99501	Polycythemia rubra vera	99503
99601	Chronic myeloproliferative disease, NOS	99603
99601	Chronic myeloproliferative disorder	99603
99611	Myelosclerosis with myeloid metaplasia	99613
99611	Megakaryocytic myelosclerosis	99613
99611	Myelofibrosis with myeloid metaplasia	99613
99621	Idiopathic thrombocythemia	99623
99621	Essential thrombocythemia	99623
99621	Essential hemorrhagic thrombocythemia	99623
99621	Idiopathic hemorrhagic thrombocythemia	99623
99801	Refractory anemia, NOS	99803
99801	Refractory anemia without sideroblasts	99803
99821	Refractory anemia with sideroblasts	99823
99821	Refractory anemia with ringed sideroblasts	99823
99831	Refractory anemia with excess blasts	99833
99841	Refractory anemia with excess blasts in transformation	99843
99891	Myelodysplastic syndrome, NOS	99893
99891	Preleukemia	99893
99891	Preleukemia syndrome	99893

These terms/codes **are not reportable** starting with 01/01/2001 and forward diagnoses:

2ND ED. CODE	TERM AS IT APPEARS IN ICD-O, 3RD ED.	3RD ED. CODE
84423	Serous Cystadenoma, borderline malignancy (C56.9)	84421
84423	Serous tumor, NOS, of low malignant potential (C56.9)	84421
84513	Papillary Cystadenoma, borderline malignancy (C56.9)	84511
84623	Serous papillary cystic tumor of borderline malignancy (C56.9)	84621
84623	Papillary serous cystadenoma, borderline malignancy (C56.9)	84621
84623	Papillary serous tumor of low malignant potential (C56.9)	84621
84623	Atypical proliferative papillary serous tumor (C56.9)	84621
84723	Mucinous cystic tumor borderline malignancy (C56.9)	84721
84723	Mucinous cystadenoma, borderline malignancy (C56.9)	84721
84723	Pseudomucinous cystadenoma, borderline malignancy (C56.9)	84721
84723	Mucinous tumor, NOS, of low malignant potential (C56.9)	84721
84733	Papillary mucinous cystadenoma, borderline malignancy (C56.9)	84731
84733	Papillary pseudomucinous cystadenoma, borderline malignancy (C56.9)	84731
84733	Papillary mucinous tumor of low malignant potential (56.9)	84731

Other methods for identifying reportable cancer cases can be developed to assure complete case reporting. Since the patient's medical record is the primary source of information, arrangements should be made so the appropriate charts can be routed to the personnel responsible for reporting. These charts could be stamped and placed on a shelf marked for Tumor Registry use.

The pathology department reports will need to be routinely checked. The best procedure is to have a copy of ALL pathology reports routed to the personnel responsible for reporting. All pathology reports (both positive and negative) will need to be reviewed by the reporter to ensure all eligible cases are identified. Request that all cytology, hematology, bone marrow biopsies, and autopsies be included. Both computerized and manual methods of reviewing pathology reports must include a way to track reports to ensure that each report has been included in the review. Facilities that send all pathology specimens to outside labs should keep a log of all specimens, to include date sent out, date received, and the diagnosis. The reporter should be given a copy of all reports.

For facilities with radiation oncology departments, a procedure must be established to identify patients receiving radiation therapy. This should include all inpatient and outpatient treatments. Different options, such as copies of the treatment summary, a treatment card, or even a daily appointment book may be available to identify these cases.

Many cancer patients are seen in the outpatient department, hematology clinic, laboratory, emergency room, nuclear medicine, and diagnostic radiology and oncology departments. A method to identify reportable cases from these departments must also be established. A good place to start is the daily appointment books.

Many facilities now have a designated oncology/hematology unit where patients receive chemotherapy treatments as an inpatient. In some cases, patients receive chemotherapy in an ambulatory setting, a freestanding facility or a physician's office. The registrar/reporter must establish a policy and procedure for identifying patients who receive chemotherapy in these settings if affiliated with their facility.

A reportable case should be abstracted after review of the patient's complete record, not just from the unit record for the admission in question. If reportable cases are identified at the time of discharge, the complete medical record will not be available for use to abstract the case. A suspense file can be compiled of all cases identified as eligible or potentially eligible for abstracting. The suspense file can be something as simple as a manila folder to hold the different casefinding source documents (monthly disease index, pathology reports and outpatient log sheets) in alphabetical order and/or by date of diagnosis to assess timeliness of the abstracting process.

Personnel responsible for reporting should review the table of terms that indicate a diagnosis of cancer on page 16. Upon review of the disease index, cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (173.0-9), and CIN of the cervix (233.1). A listing of these cases should be kept for each individual year. The TCR conducts casefinding audits when facilities should have completed reporting for a given year and will need to review your non-reportable list and your disease index (see page 13). The non-reportable list will answer any questions TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable. *Attachment B* (page 28) is a sample form that can be used as a history file of the non-reportable cases. You can also document your non-reportable cases on the disease index. Place the notation NR next to the patient information and include a justification if you determine the case is not reportable. Another method would be to develop an electronic spreadsheet utilizing Excel or Word that can be sorted alphabetically. An alphabetical card index file can also be used. If you abstract and report your cases using SCL v.8, a new feature has been added to record your non-reportable cases. Please refer to the SCL User's Guide for instructions.

EXAMPLES:

1. The ICD-9-CM billing code indicates current disease. Reason for admission was radiology and laboratory testing. All radiology and laboratory findings do not indicate active disease. *This case is not reportable.*

2. The discharge summary and face sheet states history of cancer and there is no other information within the chart to indicate active or stable disease. *This case is not reportable*.

3. A patient is admitted for evaluation of congestive heart failure. The patient had a mastectomy for breast cancer 8 years ago and there is no evidence of recurrent or metastatic disease. *This is not a reportable case.*

4. A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2003, the patient was admitted and diagnosed with small cell carcinoma of the lung. *The 2003 case is reportable.*

5. Discharge summary diagnosis states cancer and the ICD-9-CM billing code indicate current Disease. All laboratory findings are negative for active disease, but one radiology report indicates active disease. *This case is reportable.*

6. A patient is admitted to your facility with an acute cerebrovascular accident. The H&P states the patient was diagnosed with metastatic lung cancer four months prior to admission. He was treated with palliative care and referred to the Hospice program. All indications are that this patient still has active cancer. *This is a reportable case.*

7. A patient was diagnosed with cervical cancer in 2000 and has had no recurrence. She is now admitted and diagnosed with a second primary in the lung. *The lung case is reportable.*

8. A patient comes to your facility for port-a-cath insertion to allow for chemotherapy. This documentation indicates the patient has active disease. *This is a reportable case.*

NOTE: In most cases, the patient's record clearly presents the diagnosis by use of specific terms, which are synonymous with cancer. There will be times when a physician is not certain or the documented language is not definitive.

Rules concerning the usage of ambiguous terminology (vague or inconclusive diagnostic language) are as follows:

AMBIGUOUS TERMS GUIDELINES	
***DO* INDICATE A DIAGNOSIS OF CANCER**	***DO NOT* INDICATE A DIAGNOSIS OF CANCER**
	Report these cases only if cancer-directed therapy is planned or given
Apparently	Approaching
Appears to	Cannot be ruled out
Comparable with	Equivocal
Compatible with	May be
Consistent with	Possible
Favor(s)	Potentially malignant
Malignant appearing	Questionable
Most likely	Rule out
Presumed	Suggests
Probable	Very close to
Suspect(ed)	Worrisome
Suspicious	
Typical (of/for)	

NOTE: The above terms are not all inclusive and the entire medical record should be reviewed before basing reportability on one of these terms. If an ambiguous term is given that is not included in the above list contact your regional office for clarification. Please note the exceptions on the following page.

EXCEPTION: *If cytology is reported as "suspicious" do not interpret this as a diagnosis of cancer. Report the case only if a positive biopsy, a physician's clinical impression of cancer supports the cytology findings, or cancer directed therapy is administered.*

NOTE: When phrases such as *strongly suspicious* or *highly questionable* are used, disregard the modifying term and refer to the guidelines above regarding the primary term. A patient stated to have "known" cancer should be reported to the TCR.

NOTE: Cases in which the disease is **no longer active** should only be reported if the patient is still receiving cancer-directed therapy, i.e., leukemia in remission receiving chemotherapy.

EXAMPLE:

1. A patient diagnosed 6 months ago with acute myelocytic leukemia is now in remission and on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the last course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

Abstract cases with a reportable diagnosis using the medical record from the first admission (inpatient or outpatient) to your facility. Use information from subsequent admissions to supplement documentation to include all first course treatment information.

NOTE: Do not submit a report for each admission; submit one per primary tumor.

EXAMPLES:

1. A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one report with all first course treatment is to be submitted.

2. A patient was already reported in 2000 from your facility for breast cancer. She is now admitted in 2004 with metastatic bone cancer. Do not submit a new report for bone cancer.

Additional guidelines for case reporting:

- Cases diagnosed and/or treated for cancer prior to admission **should be reported** if there is evidence of **active disease**, whether or not diagnostic or therapeutic procedures were performed.

  NOTE: Stable disease indicates active disease.

- Cases diagnosed at autopsy, (no suspicion prior to death that cancer existed) are reportable.
- Patients with active cancer coming into a facility for "consultation only " should be reported.
- Patients with a history of cancer, **with no evidence of active disease**, should **not** be reported.

NOTE: Remember, physicians may refer to patients diagnosed with cancer prior to coming to your facility as having a "history of" cancer. These cases should be reviewed closely to determine if the patient has active disease and/or is receiving cancer-directed treatment. If you have any questions regarding the eligibility of a case, call your regional office.

Examples:

1. A patient presents to your facility for a bone scan. The face sheet has been coded to prostate cancer. The bone scan is negative and there is no other information to indicate that this patient has active disease or is receiving cancer directed treatment. *This case is not reportable.*

2. A patient presents to the emergency room. He tells the attending physician that he had cancer years ago. There is no other information documented to indicate that he has active disease or is on cancer-directed therapy. *This case is not reportable.*

3. A patient comes into the emergency room for a broken wrist. The history/physical states that the patient is currently undergoing chemotherapy for lung cancer, but your facility does not render any treatment for the cancer diagnosis; the patient is only being treated for the broken wrist. *This case is reportable.*

4. A patient is admitted to your facility with a breast lump. The history/physical states that the patient was diagnosed elsewhere with breast cancer five years ago and treated with a lumpectomy. There is now recurrence of the disease and the patient was referred to your facility for a mastectomy. *This case is reportable due to active disease.*

Every effort should be made to identify multiple primary tumors. See *Appendix G* and *Appendix H* in the TCR handbook.

To prevent reporting the same patient with the same primary twice, compare the patient name and primary cancer site from your registry database (accession list or SCL facility data report) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

Complete cancer reporting is an important element in a cancer registry quality assurance program. The TCR is performing casefinding audits on a regular basis to determine the completeness of case ascertainment and timeliness of reporting at facilities across the state. These audits are a part of our data quality procedures and are necessary to assure complete and accurate cancer information and to meet our federal funding obligations. The results of a casefinding audit are reported back to the facility. The percentage of reportable cases identified from a casefinding audit should not exceed 5 percent.

HELPFUL HINTS TO CONDUCT CASEFINDING:

- Review pathology reports monthly.
- Review disease index monthly.
- Review radiation oncology logs weekly.
- Have coders route medical charts to the registrar/reporter on all identified cancer patients.
- Review outpatient and emergency room visits for reportability. Arrangements can be made to have these routed to the registrar/reporter, or the registrar/reporter can physically review them there.
- Maintain a table of non-reportable cases or document your non-reportable cases on the disease index.
- To achieve complete and accurate casefinding, all sources should be reviewed.
- When you are complete for a given year, check the *Yes* column on the "*All Forms Submitted For the Year"* section on the transmittal form.
- Send your disease index (see *Attachment A*), casefinding checklist (see *Attachment C*), non-reportable list (see *Attachment B*) to your regional office when you are complete for a given year.

Contact your regional office for an assessment of your casefinding procedures. This will prepare you for an audit.

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Attachment A

Sample Facility
Disease Index
2004 Cancer Cases

RUN DATE: 08/03/2001 Case Mix/Abstracting Page 40
RUN TIME: 0855 Patients

MR #	Name	Unit #	DOB	SS#	SX	PT Class/Type	Admit Date	Dischg Date	*Diagnoses/Description "Include secondary dx"
Dillydally V01644608	Dillydally, Fred W.	V323436	02/03/29	455-66-9090	M	IN.MCR	05/02/04	05/10/04	162.9 MAL NEO BRONCH/LUNG NOS
Dixey V00853788	Dixey, Charles	V174297	05/05/18	422-23-2323	M	IN.MCR	04/05/04	04/07/04	V58.1 ENCOUNTER FOR CHEMO
V00923847	Dixey, Charles	V174297	05/05/18	422-23-2323	M	SCD.MCR	05/11/04	05/11/04	189.1 MALIG NEO RENAL PELVIS
V01782648	Dixey, Charles	V174297	05/05/18	422-23-2323	M	IN. MCR	09/06/04	09/14/04	198.3 SEC MAL NEO BRAIN/SPINE
Dixey V02548046	Dixey, Ray	V416004	02/25/52	566-66-6666	M	IN.OTH	10/16/04	10/20/04	185 MAL NEO PROSTATE
Doblio V00817429	Doblio, Beth	V197988	06/05/29	500-00-5000	F	CLI.MCR	03/22/04	03/22/04	217 BENIGN NEO BREAST
V00952770	Doblio, Beth	V197988	06/05/29	500-00-5000	F	IN.MCR	05/29/04	06/02/04	174.4 MAL NEO BREAST UP-OUTER
V00978817	Doblio, Elizabeth	V197988	06/05/29	500-00-5000	F	IN.MCR	05/29/04	06/02/04	196.3 MAL NEO LYMPH-AXLLA/ARM
V08797666	Doblio, Beth	V197988	06/05/29	500-00-5000	F	RCR.MCR	07/13/04	07/13/04	V58.0 ENCOUNTER FOR RADIOTHERAPY

*Disease Index should include all primary and secondary diagnoses.

Attachment B

Facility Name **Facility ID#** **Reviewed by** **Telephone**

Note: The disease index may be used in lieu of this form to document non-reportable cases

History File for Non-Reportable Cases

Patient Name	Medical Record #	Admission Date	Date of Birth	Social Security #	Casefinding Source	Reason for not reporting

*****KEEP A COPY FOR YOUR RECORDS**

ATTACHMENT C

A checklist that can be used to document all sources utilized to achieve complete casefinding. Upon completion of abstracting for each year, the casefinding checklist should be completed and mailed to your regional TCR office. Keep a copy for your records.

Facility Name :	**Facility ID#:**	**Expected # Cases:**	**Year:**
Casefinding Source	**Available Y/N or NA**	**Reviewed Y/N or NA**	**Comments**
Accession Register			
Ambulatory Setting			
Day Surgery			
Diagnostic Radiology & Oncology			
Emergency Room			
Free-standing facility			
Hematology Clinic			
Hospice			
Medical Records Disease Index			
Nuclear Medicine			
Outpatient Department			
Pathology Department			
Autopsy Reports			
Bone Marrow Biopsies			
Cytology			
Hematology			
Histology			
Physician's Office			
Radiation Oncology Dept.			
Daily Appointment Book			
Treatment Card			
Treatment Summary			

Reviewed by: _____ Date: _____
Facility Name: _____
Mailed to Texas Cancer Registry on: _____ Telephone: _____

***** KEEP A COPY FOR YOUR RECORDS.**